Maternal and Child Health Services
Title V Block Grant

State Narrative for Wisconsin

Application for 2009
Annual Report for 2007

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.
An attachment is included in this section.

C. Assurances and Certifications

ASSURANCES & CERTIFICATIONS Attached
An attachment is included in this section.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

/2008/ The 2007 Wisconsin Title V MCH Services Block Grant Application is found on the DHFS website at http://dhfs.wisconsin.gov/DPH_BFCH/BlockGrant/. The public and interested parties in MCH and CYSHCN related services are encouraged to provide input via the website at http://dhfs.wisconsin.gov/DPH_BFCH/PublicInput.asp. The web public input section relates to the top 10 priority needs that emerged from the needs assessment. Four questions were asked:
• What are your comments or suggestions regarding the newly defined "Top 10" priority needs;
• Do you have suggestions for specific performance measures to address these needs? (e.g. Percent of women who use tobacco during pregnancy);
• Other comments; and
• List of options which best describe you.

From July 2006 through submission of the grant in July 2007, we provided the 2007 block grant application as a template and asked for public input through the DHFS website, from our partners around the state including all local health agencies, the five regional public health offices, MCH statewide projects, and the Regional Centers for CYSHCN; at advisory meetings (i.e. MCH Advisory, WAPC); community meetings (i.e. Black Health Coalition and Great Lakes Intertribal Council); and conferences and meetings involving families of CYSHCN (i.e. Circles of Life Conference). The information was gathered by state MCH program staff and shared at our staff meetings. The information from all the MCH partners and meetings along with the 20 comments from the DHFS webpage were incorporated into the writing of our 2008 grant application or as a point of reference for future planning as well as an evaluation of how we are doing communicating and meeting our state priorities and performance measures. The input received validated the need for the defined priorities and individuals offered suggestions on topics such as: oral health, mental health, contraceptive services, and health disparities. //2008//

/2009/ The "call for submissions" distribution plan used this year is the same as last year. A total of 21 comments were received through the DHFS website. The input received again validated the need for the aforementioned priorities. In addition, the following areas of need were emphasized: infant mental health awareness and provider training; dental

health access and affordability issues (especially in rural areas); adequate and appropriate nutrition and obesity and overweight, highlighting the rising problems with food insecurity; and alcohol use among pregnant women. Advocates and Benefits Counseling for Health (ABC for Health) provided input emphasizing the need for a statewide infrastructure to assist families with children and youth with special health care needs to connect to both health care coverage and medical services. Two additional venues were used to gather public input this past year, the statewide Reproductive Health and Family Planning trainings and the MCH Regional Forums that were held in each of the five health regions in the state. //2009//

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

An attachment is included in this section.

C. Needs Assessment Summary

Table 1 (see Section II. C. - Needs Assessment Summary attachment) compares Wisconsin's 2000 ten priority needs to those from 2005. Six needs are similar; 4 reflect emerging issues about mental health, medical home, overweight/at risk for overweight, and unintentional/intentional injuries. Four needs from 2000 did not align with new needs: child care, family and parenting, CYSHCN systems of care, and early prenatal care. These needs are integrated into WI's Title V programs' 2005 priorities and addressed in the new State Performance Measures (SPMs): dental services, age-appropriate social-emotional development, child maltreatment, medical home, physical exam for children, obese/overweight children, ratio of the black to white infant mortality rate, and motor vehicle teen (15-19) death rate.

Below are the two SPMs that were changed to reflect new directions for contraceptive services and dental health for 2007.

Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year

Expansion of contraceptive and related reproductive health care services highlights implementation of the Medicaid Family Planning Waiver (MFPW). An increasing volume of services to women between income levels of 185-250% of poverty is anticipated. This supports the objective in Healthiest WI 2010 to reduce to 30% unintended pregnancies among residents.

Activities related to continued promotion and outreach for the MFPW is coordinated with the Governor's 2004 Healthy Kids Initiative as it identifies a series of steps to improve child health. One step is to "Step up efforts to reduce Teen Pregnancy". WI has seen an overall decline in teen births. The MFPW is one of the most successful programs to address this issue.

Technical assistance, support, and continuing education activities for publicly supported family planning providers continue and focus training on clinic quality improvement and results from social marketing research. Increase in awareness of and access to timely contraceptive services is a priority.

/2008/ See SPM #1 for update of Family Planning Waiver activities. //2008//

Percent of Medicaid and BadgerCare recipients, ages 3-20, who received any dental service during the reporting year

DPH secured WI Partnership funds for LHDs and tribal health centers for the "Beyond Lip Service" program. Funds distributed through an application process targeted the Northern Region. Technical assistance helps maintain fluoridation of existing community water systems and increases the number considering fluoridation. The School-Based Fluoride Mouth Rinse Program provides ongoing assistance to increase numbers in elementary schools.

Oral health in the Governor's KidsFirst Initiative promotes expansion of the WI Seal-a-Smile Program, integrates preventive oral health into health care practice and increases use of dental hygienists to prevent oral disease.

Spit Tobacco Program works with DPI to serve 5th graders during the school year. A "Brewers Day in the Park" features topical comic books.

Integrating Preventive Oral Health Measures into Healthcare Practice training is offered to federally qualified health centers (FQHC), tribal health centers, LHDs, medical education, and Head Start programs serving low income infants and toddlers. The Oral Health Consultants are responsible for prevention programs in the 5 DPH Regions and local communities including CYSHCN.

DPH promotes Oral Health Surveillance surveys to establish baseline status of 3rd graders.

Chippewa Valley and Western WI Technical Colleges serve all persons as a service learning opportunity for dental hygiene students who bill for Medicaid for some services. GPR funds for CESA 11 and Marshfield Family Health Center rural dental health clinics provide preventive and clinical services to low income families.

/2008/ See SPM #2 for updated Dental Services information. //2008//

New SPMs for children with age-appropriate social and emotional development, child maltreatment, and children's medical home.

Activities for these SPMs will be in conjunction with the Wisconsin Medical Home Initiative and WISC-I Grant; the WI Infant Mental Health Initiative and the Mental Health and Social-Emotional component of the ECCS Grant; and the WI Injury Prevention Program.

/2008/ See SPM #s 3, 4, 5. //2008//

Outcome Measures - Federal and State
Table 2 (see Section II. C. - Needs Assessment Summary attachment) crosswalks the State's Priority Needs, National Performance Measures (NPMs), State Performance Measures (SPMs), and Healthiest WI 2010.

Additional Information on "Cultural Competency" and "Challenges and Barriers" can be found in the attached (see Section II. C. - Needs Assessment Summary attachment).

/2009/ Additional "challenges" include: 1) Consistent choice of priorities to be addressed by partners receiving MCH Title V dollars and 2) Ability to measure effectiveness over time, which usually takes more than one year to measure and requires our partners to continue their activities and programs for more than one year

Since submission of the previous Title V MCH Block Grant Application and Report in July 2008, there are no differences in the State's priority needs and no changes in needs assessment processes. Surveillance of disparities in birth outcomes, injury, oral health, etc. has continued to support the priorities established and the activities occurring to address the identified priorities. In preparation for the next 5 year Needs Assessment which will be submitted with the 2011 application in July 2010, the Title V Program is developing a process and workplan proposal and timeline for the activities. //2009//

An attachment is included in this section.

III. State Overview

A. Overview

STATE HEALTH AGENCY'S CURRENT PRIORITIES

Wisconsin's State Health Plan, Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public was released in early 2002. All related documents are available on CD-ROM to include:

1. State Health Plan
2. State Health Plan Executive Summary
3. Wisconsin's Stakeholders Report
4. Minority Health Report
5. Implementation Plan (All Templates and Logic Models)
6. Mapping Project
7. Local Public Health Systems Partnership Database Introduction
8. Local Public Health Systems Database
9. Healthiest Wisconsin 2010 Annual Status Report 2004

The State Public Health Plan fulfills the legislative requirement to develop a state public health plan at least once every ten years as required in Wis. Stats. 250.07. Participation in implementing and monitoring progress, over the remaining five years continues to involve diverse partners including state and local government, nonprofit and private sector, and consumers. The DPH Administrator uses the State Public Health Plan as a major reference guide to determine the importance and magnitude of maternal and child health services when compared with other competing factors that impact health services delivery in Wisconsin. With finite funds, this planning is imperative.

The Healthiest Wisconsin 2010 defines "public health" and the 12 essential public health services. The document describes the five system (infrastructure) priorities and the 11 health priorities that will set the stage for public health programs. The system priorities are: 1) integrated electronic data and information systems, 2) community health improvement processes and plans, 3) coordination of state and local public health system partnerships, 4) sufficient and competent workforce, and 5) equitable, adequate, and stable financing.
Wisconsin's 11 health priorities, listed alphabetically, are:

- Access to primary and preventive health services,
- Adequate and appropriate nutrition,
- Alcohol and other substance use and addiction,
- Environmental and occupational health hazards,
- Existing, emerging and re-emerging communicable diseases,
- High-risk sexual behavior,
- Intentional and unintentional injuries and violence,
- Mental health and mental disorders,
- Overweight, obesity, and lack of physical activity,
- Social and economic factors that influence health, and
- Tobacco use and exposure.

Underlying Healthiest Wisconsin 2010 is the comprehensive view of health that we have long embraced in the MCH/CSHCN Program. This includes not only physical and mental health but also social, spiritual, and community well-being. This view of health affirms the essence of MCH, which lies not only in the prevention and reduction of morbidity, mortality, and risk but also in the fostering of the potential for children and families to become compassionate, productive, and dignified citizens.

In 2004, we prepared a navigational tool to help LHDs see the direct connection between

Healthiest Wisconsin 2010 priorities and objectives with MCH/CSHCN Program as they consider making application for Blue Cross/Blue Shield (BC/BS) resources and negotiating for performance based contracting. This tool was important because both of Wisconsin's medical schools require that BC/BS applications align with the state health plan's priorities. (A copy of the navigational tool is available upon request.)

Intense efforts to monitor progress and track accomplishments for each of Wisconsin's 11 health priorities began in 2005. The first DHFS Annual Status Report was completed this year with the purpose to improve communication between the Department and its partners related to the implementation of Healthiest Wisconsin 2010 and to describe new initiatives that are underway. Tracking the State Public Health Plan provides access to state-level data on indicators that track progress toward meeting many of the 2010 objectives. Indicators were developed to measure a given objective based on the availability of state-level data.

Finally, results from our 2005 (required) Title V needs assessment are closely linked to seven of the 11 State Public Health Plan priorities as follows: access to primary and preventive health services; high-risk sexual behavior (which includes pregnancy); intentional and unintentional injuries and violence; mental health and mental disorders; overweight, obesity, and lack of physical activity; social and economic factors that influence health; and tobacco use and exposure.

/2007/ No significant change. //2007//

/2008/ No significant change. //2008//

/2009/ The process for developing WI's state health plan, Healthiest WI 2020, has begun. The WI MCH Program and its statewide partners were provided an overview of the process at the March MCH Advisory Committee meeting and the Family Health Section meeting. They were invited to participate on planning committees to work on the revisions and additions to the present Healthiest WI 2010 state plan which will then become the 2020 plan. //2009//

PRINCIPAL CHARACTERISTICS OF WISCONSIN

The information is adapted from the following data sources: 1) 2000 U.S. Census; 2) the State of Wisconsin, 2003-2004 Blue Book, compiled by the Wisconsin Legislative Reference Bureau, 2003; 3) the Anne E. Casey Foundation Kids Count Online Data available at: www.aecf.org/kidscount/data.htm; 4) Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Infant Births and Deaths, 2003, Madison, Wisconsin, 2004; 5) Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Deaths 2003, Madison, Wisconsin, 2004; 6) Wisconsin Department of Health and Family Services, Division of Public Health, Minority Health Program. The Health of Racial and Ethnic Populations in Wisconsin: 1996-2000. Madison, Wisconsin, 2004; 7) Council on Children and Families, Inc., 2003 WisKids Count Data Book, Madison, Wisconsin, 2003; 8) The Center on Wisconsin Strategy County Database available at: http://old.cows.org/toolkit/toolkit.asp; and 9) The Institute for Women's Policy Research, The Status of Women in Wisconsin, Washington, DC, 2004.

/2007/ No significant change. //2007//

/2008/ For the 2008 Title V Block Grant Application, the most current versions of the above data sources were used to update the principal characteristics of Wisconsin. These sources are: 1) U.S. Census Bureau, American Fact Finder, 2005 American Community Survey (http://factfinder.census.gov/), 2) the State of Wisconsin, 2005-2006 Blue Book, compiled by the Wisconsin Legislative Reference Bureau, 2005, 3) the Anne E. Casey Foundation Kids Count Online Data (www.aecf.org/kidscount/data.htm), 4) Wisconsin Department of Health and Family

Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Infant Births and Deaths, 2005 (PPH 5364-05). September 2006, 5) Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Deaths, 2005 (PPH 5368-05). September 2006, and 6) Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query system, (http://dhfs.wisconsin.gov/wish/) //2008//

/2009/ No significant change. //2009//

Population and Distribution

On April 1, 2000, Wisconsin's population was 5,363,675, according to the U.S. Census. Compared to the U.S. as a whole, with an overall 13% growth rate during the 1990s, Wisconsin's rate of growth was 10%. Wisconsin (along with 8 other states) lost a seat in the Congress in the reapportionment of the House of Representatives based on the final census counts.

/2008/ In 2004, Wisconsin's official population was 5,532,955. //2008//

/2009/ In 2006, Wisconsin's official population was 5,609,705. //2009//

Although Wisconsin is perceived as a predominantly rural state, it is becoming increasingly urbanized as reflected by the 2000 census. Sixty-eight percent of Wisconsin's population live in 20 (of 72) metropolitan counties (those counties with a city of 50,000 or more population plus those nearby counties where commuting to work is a link between the city and suburban counties); the remaining 32% of the population live in Wisconsin's 52 non-metropolitan counties. Wisconsin's population density varies greatly across the state. For example, the City of Milwaukee has 6,214 persons per square mile while Iron County, in the upper tier of northern Wisconsin has only eight people per square mile. Wisconsin's population is expected to grow with the largest amount of growth in the suburbs of metropolitan areas such as the Fox River Valley (Appleton, Green Bay, Menasha, Neenah, and Oshkosh), the counties surrounding the County of Milwaukee, and the western counties adjacent to the metropolitan area of Minneapolis/St. Paul. Despite this strong growth in major metropolitan areas, the City of Milwaukee, however, has experienced a loss of more than 31,000 residents during the 1990s, and Milwaukee County decreased by 19,000 persons.

/2008/ According to the 2005 Wisconsin Family Health Survey (Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, December, 2006), 29% of Wisconsin's household population lives in 47 nonmetropolitan counties, 11% lives in the city of Milwaukee, and 61% live in Milwaukee County and the other 25 metropolitan counties. //2008//

/2009/ No significant change. //2009//

Population characteristics: Females make up 51% of the state's population and 34% of women live outside the metropolitan areas. The 2003 population estimate for the number of children under the age of 18 was 1,339,690 or about one-fourth of the state's population. The largest percentage of children live in the southeastern portion of the state (38%) and the smallest percent of children (9%) live in Wisconsin's northern tier.

/2008/ According to the 2005 American Community Survey, females made up 51% of the household population and males 49%. The median age was 37.9 years and 24% of the population were under 18 years and 13% were 65 years and older. //2008//

/2009/ No significant change. //2009//

In 2000, non-family households (defined as one person living alone or multiple unrelated persons living together) comprised more than one-third of all households in Wisconsin and more than half of these households were headed by females; traditional families (married couples with own children) comprised 24% of Wisconsin households, compared to 30% in 1970. Like the rest of the country, the 1950s "Ozzie and Harriet" picture has changed to the "Friends" of the 21st century. Additionally, family size has decreased: the average household size in Wisconsin 50 years ago was 3.4 persons; in 2000, it was 2.5 persons.

/2007/ No significant change. //2007//

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

Vital statistics: Births to single mothers have increased slightly from 25% in 1991, 27% in 1993 and 1995, and 28% in 1996 and 1997 to 31% in 2003. The marriage rate in 2003 was 6.3 per 1,000 total population, lower than the U.S. 2003 provisional marriage rate of 7.6. The divorce rate per 1,000 residents has remained fairly static since 1993 hovering at 3.5 to 3.1 in 2003; this rate is consistently lower than the U.S. provisional divorce rate of 3.8 in 2003. Fifty-four percent of Wisconsin divorces in 2003 involved families with children under 18 years of age. In 2003, there were 42,040 deaths in Wisconsin for a rate of 8.4 per 1,000 population, slightly lower than recent years; this rate is similar to the U.S. rate.

/2007/ No significant change. //2007//

/2008/ In 2005, 33% of births were to unmarried women, a slight increase from 2004 when 32% of births were to unmarried women. The marriage rate in 2005 was 6.1 per 1,000 total population, lower than the 2004 rate of 6.2, and lower than the US 2005 provisional rate of 7.5 per 1,000 total population. The 2005 divorce rate in Wisconsin was 2.9 per 1,000 total population, lower than the 2004 rate of 3.0; the divorce rate in Wisconsin is lower than the U.S. provisional rate of 3.6. Fifty-three percent of all 2005 Wisconsin divorces involved families with children under 18 years of age. In 2005, there were 46,544 resident Wisconsin deaths for a rate of 8.3 per 1,000; this rate is similar to the U.S. death rate. In 2005, there were 15 maternal deaths, compared to six in 2004 and nine in 2003. //2008//

/2009/ No significant change. //2009//

Racial and ethnic characteristics: 2000 was the first year that census respondents were allowed to identify themselves as being of more than one race and about 1.2% of Wisconsin individuals selected multiple races. Therefore, comparisons of race/ethnic groups in Wisconsin are approached cautiously. From the 2000 census, single race and ethnic categories were the following: 88.9% White, 5.7% Black, 0.9% American Indian, 1.7% Asian (Hmong and Laotian are the two largest Asian groups), 1.6% other races, 1.2% two or more races, and 3.6% of Hispanic origin, any race. Wisconsin has 11 Indian reservations, and in 2000, the American Indian population was 47,228, a 21.1% increase from 1990.

/2007/ No significant change. //2007//

/2008/ According to the 2005 American Community Survey, for people reporting one race only, 89% were White, 6% Black, 1% American Indian, 2% Asian, less than 0.5% Native Hawaiian/Other Pacific Islander, 2% were some other race. One percent reported two or more races; 5% were Hispanic, and 86% were White non-Hispanic. //2008//

/2009/ Whites were the largest group at 90.5%, followed by blacks at 6.3%, American Indian at 1.0%, and Asian at 2.2%. Hispanics made up 4.7% of Wisconsin's population. //2009//

In 2000, almost 76% of Wisconsin's Blacks lived in Milwaukee County. Two counties, Milwaukee and Racine, have Black populations that are more than 10% of the population; Milwaukee (24.6%) and Racine (10.5%). Also, for the first time, more than half of Milwaukee County's population was non-White. Thirty-nine percent of Wisconsin's children live in the southeastern portion of the state which includes the county and city of Milwaukee.

Selected indicators of child well-being in Wisconsin

Since 1990, Wisconsin's percentage of children has decreased from 14.9 in 1990 to 11.2% in 2000. Although poverty rates in 2000 for all race and ethnic groups decreased since 1990, the table below shows that minorities carry the burden of poverty in Wisconsin.

See Attachment for Section III. A. - Overview
(Table 1 - Children Living in Poverty)

/2007/ No significant change. //2007//

/2008/ No significant change. //2008//

/2009/ According to the 2006 Wisconsin Family Health Survey, Wisconsin's minority and race ethnic groups have higher poverty rates than the majority white non-Hispanic population. The percentage of "poor" (<100 FPL) among all children 0-17 in Wisconsin is 13%, African American is 61%, Hispanic is 47%, and White is 6%. //2009//

Income and Poverty

In 2004, Wisconsin's not seasonally adjusted unemployment rate was 4.9%, compared to the U.S. rate of 5.5%. Although seven percent of White women live in poverty in Wisconsin (one of the lowest percentages for White women in all but 7 states), 30% of Black women, 20% of American Indian women, 21% of Hispanic women, and 16% of Asian women live in poverty. The unemployment rate for Black women in Wisconsin is nearly twice as large as Black women nationally, and Black women here are three times as likely to live in poverty as White women. Children in Wisconsin are more likely to live in poor families; the disparity of the percentage of Black children living in poverty is six times greater than White children, is greater than any other state, and is exceeded only by the Black/White child poverty of Washington, D.C. The poverty rate for Black families in Wisconsin was 39%, the fourth highest in the country. Also, in 2000, nearly one-third of Blacks in metropolitan Milwaukee lived in poverty -- a rate seven times greater than for Whites in the same area. Overall, the percentage of children under 18 who live in poverty in Wisconsin is 11%. The range of the percentage of children who live in poverty by county is significant, from the counties with the highest poverty rates for children (Menominee at 39.6%, Milwaukee at 23.3.%, Vernon at 22.8%) to the counties with the lowest poverty rates for children (Ozaukee at 2.6%, Waukesha at 3%, and St. Croix at 3.9%). About 25% of American Indian and Asian American single-mother families in Wisconsin are poor, as is about one-third of Hispanic single--mother families.

/2007/ No significant change. //2007//

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

Wisconsin's Racial and Ethnic Composition and Health Disparity

It is expected that Wisconsin's population will continue to increase in racial and ethnic diversity to further enrich the state. The population of Wisconsin is primarily non-Hispanic White (89% in 2000). The racial and ethnic groups of Blacks, American Indians, Southeast Asians, and

Hispanics report a youthful age structure with proportionately more women entering the childbearing ages.

In 2000, Blacks represented the largest racial minority group comprising about 5.7% of the total population. The Hispanic-origin population (of any race) constituted the second largest minority group in Wisconsin (3.6%). Although births to Hispanic women still constitute a small percentage (7.9%) of Wisconsin's total 2003 births, this percentage of Hispanic births has tripled in the last ten years. The American Indian population in Wisconsin includes several distinct nations: the Chippewa (Ojibwa), Oneida, Winnebago, Menominee, Stockbridge-Munsee, and the Potawatomi. The 2000 Census count was 47,228 American Indians in Wisconsin, an increase from 38,986 in 1990. The Southeast Asian population (includes people of diverse national origins to include Hmong, Laotian, Vietnamese, Thai, and Cambodian) has grown from 52,782 people in 1990 to 88,763 in 2000.

/2007/ No significant change. //2007//

/2008/ No significant change. //2008//

/2009/ In 2006, Blacks and Hispanics were the largest minorities at 6.3% and 4.7% respectively, followed by Asicans (2.2%) and American Indians (1.0%). //2009//

The attached table, from the Anne E. Casey Foundation, Kids Count 2004 Data Book Online, presents major indicators of child well-being in Wisconsin compared to the U.S. in 2001. See Attachment for Section III. A. - Overview (Table 2 - Child Well-Being Indicator).

Compared to other states, using these indicators, Wisconsin's overall rank is 11. These indicators do not reflect the significant disparities by racial/ethnic group in the state; selected indicators are discussed below:

/2007/ The 2005 On-line Anne E. Casey's Foundation's Kids Count ranked Wisconsin #10. //2007//

/2008/ The 2006 On-line Anne E. Casey's Foundation's Kids Count rank overall for Wisconsin in 2003/2004 was #13. //2008//

/2009/ The 2007 On-line Anne E. Casey's Foundation's Kids Count rank overall for Wisconsin in 2004/2005 was 12. //2009//

• Infant mortality -- Often used as a measure of a society's overall well-being, is a significant issue in Wisconsin. The overall infant mortality in 2003 was 6.5 per 1,000 live births; the White rate was 5.3, a slight decrease from 5.5 in 2000, and a marked decrease from 7.0 in 1993. The Black infant mortality rate in 2003 was 15.3; in 1997 it was at its lowest for the past two decades at 13.4. Since then it increased steadily, to 18.7 in 2001, and aside from some fluctuations to the 1997 rate, it is essentially the same now as it was in 1980 at 18.2. In fact, because Black infant mortality has improved in other states, from 1999-2001 Wisconsin dropped to among the lowest, ranking 32 among 34 states. There are too few infant deaths in the other racial/ethnic groups to calculate annual rates. Therefore, the following three-year averages from 2001-2003 are American Indian: 12.9, Hispanic: 6.9, Asian (Laotian/Hmong): 7.6.

/2007/ Wisconsin's overall infant mortality in 2004 was 6.0 deaths per 1,000 live births; the White rate was 4.5 per 1,000, and the Black infant mortality rate was 19.2; the ratio of the Black infant mortality rate to the White rate was 4.3. For the other racial/ethnic groups in Wisconsin, we calculated three-year averages for 2002-2004; they are: American Indian at 9.0, Hispanic at 6.2, and Asian (Laotian/Hmong) at 8.3. //2007//

/2008/ Wisconsin's overall infant mortality rate in 2005 was 6.6 deaths per 1,000 live births; the

White rate was 5.6 per 1,000, and the Black infant mortality rate was 15.0; the ratio of the Black infant mortality to the White rate was 2.7. For the other racial/ethnic groups in Wisconsin, we calculated three year averages for 2003-2005; they are: American Indian at 7.5, Hispanic at 6.2, and Asian (Laotian/Hmong) at 8.6. //2008//

/2009/ Wisconsin's overall infant mortality rate in 2006 was 6.4 per 1,000 live births (462 infants under the age of one year died); the White rate was 4.9 per 1,000 and the Black infant mortality rate was 17.2 per 1,000 live births. The ratio of the Black infant mortality rate to the White rate was 3.5. For the other racial/ethnic groups in Wisconsin, we calculated three year averages for 2004-2006; they are: American Indian at 8.1, Hispanic at 6.0, and Laotian/Hmong at 6.5. //2009//

• Low birth weight/preterm -- In 2003, in Wisconsin, 6.6% of all births were infants with low birth weight, Black infants (13.2%) were about 2 times as likely as White infants (5.8%) to be born low birth weight. Also in 2003, 11.0% of infants were born prematurely, with a gestation of less than 37 weeks; non-Hispanic Black women had the highest percentage of premature babies at 16.7%, followed by American Indian and Laotian/Hmong women at 11%, and White Hispanic women at 10%.

/2007/ In 2004, 7.0% of all births were infants with low birth weight; the rate for Black infants was 13.7%, the rate for White infants was 6.3%; the rates for American Indian, Hispanic, and Asian (Laotian/Hmong) infants were 5.9%, 6.6%, and 7.0% respectively. In 2004, 11.0% of all births were born prematurely (the same rate as 2003); non-Hispanic Black women had the highest percentage of premature babies at 17.1%, followed by American Indians at 13.8%, Asian (Laotian/Hmong) at 11.5%, and Hispanics at 10.6%. //2007//

/2008/ In 2005, 7.0% of all births were infants with low birth weight; the rate for Black infants was 13.7%, the rate for White infants was 6.3%, the rates for American Indian, Hispanic, and Asian (Laotian/Hmong) infants were 5.4%, 6.5%, and 6.8% respectively. In 2005, 11.3% of all births were premature; non-Hispanic Black women had the highest percentage of premature babies at 17.9%, followed by Asian (Laotian/Hmong) at 11.6'%, Hispanic at 11.5%, and American Indian at 11.4%. Teenagers, women who are unmarried, who smoked during pregnancy, and with less than a high school education are at the highest risk of having a premature baby. //2008//

/2009/ In 2007, 6.9% (4,994) of all births were infants with low birth weight; the rate for Black infants was 13.5%, the rate for White infants was 6.2%, the rates for American Indian, Hispanic, and Laotian/Hmong were 6.8%, 6.2%, and 6.1% respectively. In 2006, 11.2% (8,104) infants in Wisconsin were born prematurely (with a gestation of less than 37 weeks). Non-Hispanic Black women had the highest percentage of premature babies at 17.8%, followed by teenagers less than 18 years old at 15.3%, women who were unmarried (13.6%), women who smoked during pregnancy (13.0%), and women with less than a high school education (13.5%). //2009//

• First trimester prenatal care -- Overall, in 2003, 84.7% of pregnant women in Wisconsin received first trimester prenatal care. Among Black and American Indian women, 73.5% and 71.0% respectively, received prenatal care during the first trimester, compared to 88.3% for White women, followed by Hispanic women with 71.0%, and Laotian/Hmong with 54.2%.

/2007/ In 2004, 85% of pregnant women received first trimester prenatal care. Black, Hispanic, and American Indian women, had comparable rates of prenatal care at 76.5%, 71.9%, and 71.7% respectively. Asian (Laotian/Hmong) women had the lowest rate of first trimester prenatal care at 56.6%. //2007//

/2008/ In 2005, 85% of pregnant women received first trimester prenatal care. Black, Hispanic, and American Indian women had comparable rates of prenatal care at 75.7%, 72.7%, and 74.4% respectively. Asian (Laotian/Hmong) women had the lowest rate of first trimester prenatal care at

56.7%. //2008//

/2009/ In 2006, 83.8% of pregnant women received first trimester prenatal care. The race/ethnic group with the highest rate was white women at 87.4%, followed by African American women at 74.4%, Hispanic/Latino at 72.3%, American Indian at 71.8%, and Laotian and Hmong at 58.8%. From 1996 to 2006, the proportion of women receiving first-trimester prenatal care increased within each race/ethnicity group except whites. The increase was especially striking among African American and Laotian/Hmong women from 66% to 74% for blacks and 47% to 59% for Laotian and Hmong. //2009//

• Teen birth rate -- In 2003, for teens <20 years, there were 6,317 births (rate of 32.5 per 1,000); by race/ethnic groups, there are disparities with Hispanic teens at the highest rate at 104.9, followed by Black teens (99.9), American Indian teens (76.2), and White teens (20.3). In 2003, as a percentage of all births, 9% were to teens; 24% of Black births to teens, 21% of Laotian/Hmong births to teens, 19% of American Indian births to teens, 16% of Hispanic births to teens, and 6% of White births to teens. Of the 50 largest U.S. cities, Milwaukee had the second highest percent of total births to teens with 2,021 births; these Milwaukee teen births represented 31% of teen births statewide.

/2007/ In 2003, for teens <20 years, there were 6,087 births (rate of 30.5/1000: by race/ethnic groups, there are disparities with Hispanic teens at the highest rate of 97.2, followed by Black teens (94.3), American Indians (60.5), and White teens (19.0). In 2004, as a percentage of all births, 8.7% were to teens; 23% of Black births to teens, 21% of Laotian/Hmong births to teen, 19% of American Indian births to teens, 16% of Hispanic births to teens, and 6% of White births to teens. //2007//

/2008/ In 2005, for teens <20 years, there were 6,093 births (rate of 30.5/1000, the same as 2004), or 8.5% of all births in Wisconsin. The following shows the overall decline in teen birth rates by race/ethnicity during the past decade.

Teen birth rates, for 15-19, by race/ethnicity in Wisconsin, 1995 compared to 2005:

Race/ethnicity
Total for 1995=38.8, for 2005=30.5
White for 1995=26.3, for 2005=19.2
Black for 1995=141.8, for 2005=94.5
Hispanic for 1995=103.4, for 2005=89.8
//2008//

/2009/ In 2006, for teens <20 years, there were 6,100 births (rate of 30.6 per 1,000), or 8.4% of all births in Wisconsin. Teen birth rates for 15-19 by race/ethnicity in Wisconsin, 1996 to 2006:

Race/ethnicity
Total for 1996=30.1, for 2006=30.6
White for 1996=24.9, for 2006=19.1
Black for 1995=133.3, for 2006=93.8
American Indian for 1995=73.2, for 2006=74.4
Hispanic for 1996=97.4, for 2006=94.6
//2009//

• Leading causes of death -- The attached table shows the five leading, underlying causes of death in Wisconsin, compared to race groups, all ages, 2003.*

See Attachment for Section III. A. - Overview
(Table 3a - Percent of Leading Underlying Causes of Death by Race, Wisconsin, 2003)

In 2003, the two leading causes of death statewide and for Whites were cancer and heart disease at more than 50%; 42% of all Blacks deaths were from heart disease or cancer, and the percentage of American Indians and Asians dying from heart disease and cancer were similar at 39.9% and 38.5% respectively. Chronic health conditions represented a smaller proportion of overall deaths for minorities because of the higher proportions of deaths in younger age groups such as injury or accidents, which occur more frequently. The third leading cause of deaths for American Indians and Asians was accidents at 10%, compared to 5% overall for Whites and Blacks. Violence (homicide) was the fifth leading cause of death among Blacks at 5% and was not a leading cause of death among other groups or statewide. About 6% of all American Indian deaths were from diabetes, but is not among the five leading causes of deaths for other groups or statewide; most of these American Indian deaths from diabetes were between the ages of 45-74.

/2007/ No significant change. //2007//

/2008/ In 2005, the three underlying causes of death were diseases of the heart, malignant neoplasms (cancer) and cerebrovascular diseases (stroke), accounting for 55% of Wisconsin resident deaths.

See Attachment for Section III. A. - Overview
(Table 3b - Percent of Top 5 Leading Underlying Causes of Death by Race, Wisconsin 2005)
//2008//

/2009/ No significant change. //2009//

FACTORS IMPACTING UPON THE HEALTH SERVICES DELIVERY ENVIRONMENT

Medicaid is the single most important government program to provide access to health care for low and middle income children and families. Today, about 1 in 7 Wisconsin residents rely on Medicaid for comprehensive health care coverage they would not otherwise be able to afford. Four major groups received medical services through Medicaid: the aged, the blind/disabled, the Healthy Start population, and recipients who qualified under the former Aid to Families with Dependent Children (AFDC) standards. Of the total Medicaid-eligible recipients, well over half were eligible through AFDC or Healthy Start, accounting for 19% of Medicaid expenditures. The aged/blind/disabled make up approximately 35% of the eligible population and account for 81% of the program expenditures.

The Wisconsin Medicaid budget continued to increase in 2004, in concert with national budget trends for Medicaid. Total expenditures for the program, rose by 9% in the 2003-04 state fiscal years, compared with the previous state fiscal year. Total expenditures were at $4.4 billion in all funding sources. These budget figures include Medicaid, Badger Care, Family Care, and Senior Care drug benefits. Governor Doyle's administration has preserved the health care safety net for vulnerable populations and has not cut Medicaid services or eligibility.

/2007/ No significant change. //2007//

/2008/ BadgerCare Plus Legislative Proposal
In announcing his "Affordability Agenda" in January 2006, Governor Jim Doyle stated that "no child should ever be without health insurance." The policy solution to ensure that all of Wisconsin's children have access to health care is creation of a single health care safety net--BadgerCare Plus. The detailed proposal, being considered in the 2007 state legislative session for implementation starting January 2008, describes Wisconsin's strategies for achieving the four strategic goals of the initiative.
1. Cover all children
2. Provide coverage and enhanced benefits for pregnant women
3. Simplify the program

4. Promote prevention and healthy behaviors

BadgerCare Plus will merge Family Medicaid, BadgerCare, and Healthy Start to form a comprehensive health insurance program for low income children and families. Coverage will be expanded to seven new populations.
1. All children (birth to age 19) with incomes above 185 percent of the federal poverty level (FPL)
2. Pregnant women with incomes between 185 and 300 percent of the FPL
3. Parents and caretaker relatives with incomes between 185 and 200 percent of the FPL
4. Caretaker relatives with incomes between 44 and 200 percent of the FPL
5. Parents with children in foster care with incomes up to 200 percent of the FPL
6. Youth (ages 18 through 20) aging out of foster care
7. Farmers and other self-employed parents with incomes up to 200 percent of the FPL, contingent on depreciation calculations

In addition, Wisconsin will streamline eligibility; assist employees in purchasing quality, employer-sponsored coverage; and provide incentives for healthy behaviors. This proposal represents the most sweeping reform of the low-income, family portion of the Medicaid program in Wisconsin since its inception in 1967. The state is also seeking federal approval for the changes, which, like the BadgerCare Plus legislative and budget process, has an uncertain timeframe.

ACCESS Summary and Update

ACCESS is a set of online tools for public assistance programs that allows customers and prospective customers to assess eligibility for programs, check case benefits and report case changes. Significantly, in mid-2006, an upgrade allowed for limited online program application. For many, this is an appealing alternative to office visits and phone calls. Although they may not own a personal computer, a growing number of customers do have access to computers -- through friends or family, at work, at school or at the library. Others use online tools with the help of staff/volunteers at food pantries, clinics, HeadStart programs, Community Action Agencies, WIC clinics, Job Centers, etc.

The goals of the ACCESS project are to:
• Increase participation in FoodShare, Medicaid, and other programs
• Improve customer service and satisfaction
• Improve FoodShare payment accuracy
• Ease workload for local agencies

Some of the key features of ACCESS are:
• Design was based on direct input from customers. More than 15 focus groups and design review sessions were undertaken with low-income residents of Wisconsin
• Friendly, encouraging text written at a 4th grade reading level
• Personalized pages, results and next steps
• Quick, simple, intuitive navigation
• For some people, ACCESS is the first website they've ever used
• Assurance about privacy. Some are nervous about giving personal information online

The major components of ACCESS are:
• Am I Eligible? -- A 15-minute self-assessment tool (launched 8/16/04) for:
*FoodShare
*All subprograms of Medicaid
*SeniorCare and Medicare Part D
*Women, Infants and Children (WIC)
*The Emergency Food Assistance Program
*School meals and summer food assistance
*Tax credits (EITC, Homestead and Child Credit)
*Home Energy Assistance

• Check My Benefits -- An up-to-date information segment (begun 9/30/05) that includes:
*Displays information about Medicaid, FoodShare, SeniorCare, and SSI Caretaker Supplement benefits
*Information displayed is based on why customers call their workers
*Provides data directly from CARES (automated eligibility system)
*Data is "translated" to make it more understandable
*Data is furnished real time at account set-up, and is then updated nightly

• Apply For Benefits -- An online application for FoodShare, Medicaid and the Family Planning Waiver program (launched 6/2/06)

Medicaid Enrollment Update

Enrollments continued to grow for the Wisconsin Medicaid program, following a trend nearly a decade old. For state fiscal year 2005-2006, enrollments grew by 3.3% from the previous year in the "family Medicaid" segment of the program -- Medicaid, Healthy Start for pregnant women, infants and children, and the SCHIP program known as BadgerCare. For 2005-2006, the total of family Medicaid enrollees grew to 414,809 from 401,622. Overall, the average number of Medicaid enrollees increased to 651,768 -- a 3.6% increase from the previous year.

Total Medicaid expenditures for the most recent completed state fiscal year of 2005-2006 were at $4.5 billion. Governor Doyle's BadgerCare Plus proposal, currently being considered in the Legislature, carries with it the central goal of covering all Wisconsin children with its broad array of services. //2008//

/2009/ In February, 2008, the BadgerCare Plus program began implementation statewide. The program provides a Standard Plan that covers usual Medicaid services and a Benchmark Plan for members with incomes greater than 200% FPL that is more restrictive with higher co-pays. By the end of February, more than 71,000 additional children and families have received comprehensive health insurance coverage. Of that total, 13,500 parents and children reside in Milwaukee County, the state's most populous and highest need urban area. The overall increase far exceeds the state's budget projections for the program's first 12 to 18 months.

Due to the expansion and consolidation of family Medicaid programs into BadgerCare Plus, the "family Medicaid enrollment" category continues to grow. In the most recently available figures, the total family Medicaid program enrollees now under "BadgerCare Plus" was 555,373, as of February 29. This total is up from about 484,000 on February 11. //2009//

Wisconsin Works (W-2)

Wisconsin's Temporary Assistance to Needy Families program is referred to as the Wisconsin Works program. It replaced the Aid to Families with Dependent Children program, and it requires recipients to work. As of December 2004, total enrollment in the Wisconsin Works program (W-2) was about 10,800. The 2004 average monthly enrollment was 12,060.

/2007/ No significant change. //2007//

/2008/ A Doyle administration proposal in the 2007 Wisconsin Legislature would extend the amount of time a mother or other custodial parent of an infant could receive a W-2 grant from 12 weeks to 26 weeks. Mothers would be eligible to receive the $673 monthly cash benefit and would not be required to participate in W-2 employment until their infant is 26 weeks old, allowing for additional time to bond and care for their newborns during this critical attachment period.

In addition, beginning in January 2008 high risk pregnant women would be eligible for cash benefits of $673 per month, during the third trimester. This cash benefit would be limited to women who do not have children and are unmarried. //2008//

/2009/ No significant change; the above proposal was not enacted into law. //2009//

Blue Cross Blue Shield Grants

Blue Cross Blue Shield asset conversion is an endowed fund that will fund public health projects "in perpetuity". Therefore, we will continue to provide overall project and grant-writing assistance to interested agencies into the future. The first grant cycle began in 2004.

Maternal and child health proposals were well-represented among grant award winners in the first award cycle of Wisconsin's Blue Cross Blue Shield public health initiative. In the implementation (large-grant) category for the University of Wisconsin - Wisconsin Partnership Fund, for example, 10 of 13 funded projects had at least partial focus on maternal issues, children, or families. The funded value of these grants is approximately $4.5 million over three years. These funded projects are:
1. Madison Community Health Center (Adolescents)
2. DHFS (Oral Health)
3. Dane Co. Dept. of Human Services (Home Visiting)
4. WI Women's Health Foundation (First Breath)
5. Aurora Medical Center in Washington County (Fit Kids)
6. Milwaukee Birthing Project (Infant Mortality)
7. Wisconsin Association for Perinatal Care (Peridata)
8. Aurora/Sinai (Safe Mom/Baby -- Domestic Violence)
9. LaCrosse Schools (Healthy Lives for Kids with Disabilities)
10. Great Lakes Inter-Tribal Cooperative (Healthy Children/Strong Families)

The DHFS oral health project deserves particular mention in this context. Title V block grant funded staff had lead responsibility to write one of the only Department-sponsored projects because of the high priority the Department places on oral health. Under the Department's directive, however, virtually all of the $450,000 in the oral health project award is being passed through to community entities, including mini-grants to local health departments in the state's Northern Region. These health departments will implement several preventive strategies with a pediatric focus, including a fluoride varnish initiative.

/2007/ No significant change. //2007//

/2008/ In the 2007 round of funding, six maternal and child-oriented Wisconsin Partnership Program (WPP) proposals were awarded by both medical schools in this continuing public health initiative. MCH proposals have been well-represented among awardees in the early years of these programs, so we will continue to provide overall project and grant-writing assistance to agencies in the future.

Large-grant funded implementation projects (up to $450,000) in 2007 were:
1. Covering Kids and Families (University of Wisconsin)
2. Covering Kids and Families (Medical College of Wisconsin)
3. Fight Asthma Milwaukee Allies
4. Milwaukee Kids: Drive Me Safely
5. Milwaukee Nurse Family Partnership Program
6. HealthWatch Wisconsin

The Blue Cross Blue Shield asset conversion endowment, controlled by the state's two medical schools, amounts to nearly $700 million in total. As such, it is one of the largest such Blue Cross/Blue Shield endowments in the country. The first grant cycle began in 2004; grant funding

will continue "in perpetuity." //2008//

/2009/ Children and families continue to receive a significant number of awards from the Blue Cross/Blue Shield asset conversion endowment made in 2007 for a 2008 start date. Of the 10 major awards worth roughly $5 million awarded by the University of Wisconsin program, seven had a major focus affecting children and families.

Those seven grant proposals are:
1. Keeping Kids Alive in Wisconsin;
2. Eco-cultural Family Interview Project;
3. Expanding and Sustaining the 'Safe Mom/Safe Baby' Project;
4. Allied Drive Early Childhood Initiative;
5. Underage Drinking -- A Parent Solution;
6. It Takes a Community to Help a Smoker;
7. Expanded Community Role in the Milwaukee Homicide Review Commission.

At the Medical College of Wisconsin, the second medical school to receive Blue Cross/Blue Shield funding, the Healthier Wisconsin Partnership Program awarded 13 large-grant proposals worth about $5.8 million in early 2008. Of those 13 winning grants, 3 were substantially oriented to children and families:

1. Healthy Youth: Strong and Connected,
2. Making Milwaukee Smile,
3. Salud de la Mujer: Community Developed Materials to Increase Health Literacy in a Latino Community. //2009//

/2008/ Licensed Midwives

New legislation became effective May 1, 2007 licensing midwives without a nursing degree. In Wisconsin, in 2005, about 1,100 Wisconsin infants were born outside a hospital. This law also frees certified nurse midwives from having a written agreement with a health care authority and allows them to mentor and train lay midwives. Wisconsin's MCH Program is supportive of the lay midwives, and organizes meetings about twice a year, in part, to facilitate communication between the state and the midwives who serve populations, e.g., the Amish, who may seek care from non-traditional health care providers. //2008//

/2009/ Certified midwives partnered with the UW Waisman Center to apply for and received a March of Dimes grant for educational materials for Wisconsin's Amish and Mennonite communities to promote prenatal, postpartum and infant care including newborn screening for metabolic disease and newborn hearing screening. //2009//

/2008/ Tobacco Funding

The current Wisconsin Tobacco Prevention and Control Program is a funded $10 million dollar program, focusing on providing funding to local tobacco coalitions throughout the state, youth program designed to reduce and prevent smoking among youth, cessation services, media and counter marketing, surveillance and evaluation of tobacco related data, and programs focused on reducing tobacco use among disparity populations. Governor Doyle has proposed an increase in tobacco program funding from $10 million to $30 million dollars, and has proposed a statewide smoking ban. He has also proposed an increase to the current cigarette tax of $0.77 to a $1.25 tax per pack. //2008//

/2009/ The current Wisconsin Tobacco Prevention and Control Program is a $15 million dollar program, focusing on providing funding to local tobacco coalitions throughout the state, youth programs designed to reduce and prevent smoking among youth, treating tobacco dependence services, eliminating the exposure to secondhand smoke through

policy development, media and counter marketing campaigns, surveillance and evaluation of tobacco related data, and programs focused on reducing tobacco use among disparity populations. //2009//

/2008/ Oral Health Funding

The Wisconsin Department of Health and Family Services initiated a one-time grant program to create or improve local community efforts to increase access to oral health services. The purpose of the project is to improve access to preventive and restorative oral health services for children - including those who are eligible for Medicaid or BadgerCare, and those who are uninsured or underinsured. In addition, specific target populations were pregnant women and persons with disabilities. Grants in the amount of $4.1 million were awarded to various organizations and agencies throughout the state for this Dental Access initiative. Grant awards ranged between $25,000 and $500,000. //2008//

/2009/ This was a one-time Dental Access grant program. There were 16 projects that received funding. Some of the projects expended all of their funds by the end of 2007 or early 2008. There are a few projects that requested and were granted extensions. All of these contracts end on September 31, 2008. There will be no funding or projects from this source in 2009. //2009//

Reproductive Health and Family Planning Services, Waiver and Outreach Efforts

According to the latest report prepared by the Alan Guttmacher Institute, 634,250 (among the 1,235,190 women in Wisconsin ages 13-44) are estimated to be at risk of unintended pregnancy and in need of contraceptive services and supplies. Of this number, 230,060 are estimated to be at risk of unintended pregnancy and in need of publicly supported contraceptive services: this includes 95,350 under age 20, and 134,710 between the ages of 20-44 and under 250% of poverty. This group is at high risk for unintended pregnancies, and the health, financial, and social consequences to women, children, and families. Low income women are particularly vulnerable to the consequences.

/2007/ No significant change. //2007//

/2008/ According to the latest report prepared by the Alan Guttmacher Institute, 640,450 (among the 1,239,470 women in Wisconsin ages 13-44) are estimated to be at risk of unintended pregnancy and in need of contraceptive services and supplies. Of this number, 235,120 are estimated to be at risk of unintended pregnancy and in need of publicly supported contraceptive services: this includes 95,330 under age 20, and 139,790 between the ages of 20-44 and under 250% of poverty. This group is at high risk for unintended pregnancies, and the health, financial, and social consequences to women, children, and families. Low income women are particularly vulnerable to the consequences. //2008//

/2009/ No significant change. //2009//

The Wisconsin Medicaid Family Planning Waiver was approved and implemented January 1, 2003, to increase access to family planning services and supplies for low income women (below 185% poverty) ages 15-44. Through the outreach efforts of family planning providers under contract with the MCH-Family Planning Program, over 58,000 women were enrolled in the Waiver Program as of March 31, 2005. This represents approximately 18% of the estimated need for publicly supported services and supplies.

/2007/ Over 64,000 women were enrolled in the Waiver Program as of March 31, 2006, representing approximately 22.7% of the estimated need. //2007//

/2008/ The Wisconsin Medicaid Family Planning Waiver was approved and implemented January

1, 2003, to increase access to family planning services and supplies for low income women (below 185% poverty) ages 15-44. Through the outreach efforts of family planning providers under contract with the MCH-Family Planning Program, approximately 63,000 women were enrolled in the Waiver Program as of December 31, 2006. This represents approximately 22% of the estimated need for publicly supported services and supplies. The FPW will be submitted to include males. //2008//

/2009/ The Wisconsin Medicaid Family Planning Waiver was renewed as of January 1, 2008. Income eligibility was increased from 185% to 200% for women ages 15-44. Approximately 59,799 women were enrolled in the FPW as of December 31, 2007. This represented 21% of the estimated eligibility for the FPW. Enrollment decreased from 2006 to 2007. Additional enrollment process necessitated by the Deficit Reduction Act requirements probably resulted in decreased enrollment. //2009//

Increasing awareness about the Medicaid Family Planning Waiver, how to enroll, and how to obtain services is a high priority within the MCH-Family Planning Program. The goal is to provide information that will allow women to make informed decisions regarding enrollment. Providers will be encouraged to further collaborate with other community health providers in 2005 and 2006 to increase awareness and to increase access to services. A related priority will be to make contraceptive and related reproductive services more convenient: to reduce office protocols and other administrative barriers to services. Making services more convenient has considerable potential to enhance outreach success.

/2007/ In January 2006 Wisconsin implemented a five year program plan to increase early intervention and detection of pregnancy. The goals of the program are to increase enrollment into the Family Planning Waiver, increase access to emergency contraception, increase use of dual protection, and make reproductive services more convenient. //2007//

/2008/ In 2007, Wisconsin will launch a new adolescent pregnancy prevention and Medicaid Family Planning Waiver initiative in Milwaukee to reach adolescents and young adults at high risk of unintended pregnancy. //2008//

/2009/ The Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP) which encompasses two clinics, a large local health department and a local community-based organization continues to make progress toward the following goals: 1) develop a Milwaukee driven, community-based partnership focused on adolescent pregnancy prevention for African Americans, ages 15-19; 2) increase the Medicaid Family Waiver enrollment in Milwaukee; and 3) successfully implement the evidenced-based, dual strategy for addressing adolescent pregnancy prevention. A key challenge for this initiative is to find innovative ways to directly engage African American youth from non-traditional and ethnically diverse communities to deliver evidenced-based teen pregnancy and STD prevention messages.

The MAPPP will make significant numerical and qualitative inroads to increase participation in the Medicaid Family Planning Waiver and will establish clear communication and coordination mechanisms with Milwaukee organizations charged with teen pregnancy, teen parenting, adolescent reproductive health services, and advocacy. MAPPP will be forming a Teen Advisory Committee to help them increase the outreach and efficacy of the Family Planning Waiver to African American youth. This may take the shape of teen-to-teen teaching moments based on the train-the-trainer concept and create a more user-friendly name for the Waiver. //2009//

Wisconsin is in the midst of dealing with a budget deficit, a declining health care work force, people in need, and negative health outcomes associated with racial disparities. Given the state of Wisconsin's health care delivery environment, some could argue that Title V dollars are needed more today than ever before in order to fill the gaps and meet the needs where no other

safety net exists.

/2007/ No significant change. //2007//

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//
An attachment is included in this section.

B. Agency Capacity

WISCONSIN STATE STATUTES RELEVANT TO TITLE V MCH/CSHCN PROGRAM AUTHORITY

The Wisconsin Legislature has given broad statutory and administrative rule authority to its state and local government to promote and protect the health of Wisconsin's citizens. In 1993 Wisconsin Act 27, created Chapters 250-255 that significantly revised public health law for Wisconsin and created an integrated network for local health departments and the state health division. In 1998, Public Health Rules HFS 139 and HFS 140 were completed to provide specific guidance concerning the statutory requirements necessary to build the capacity to protect the health of Wisconsin's residents. HFS 139 outlines the qualifications of public health professionals employed by local health departments and HFS 140 details the required services necessary for a local health department to reach a level I, II, or III designation. These important public health statutes provide the foundation and capacity to promote and protect the health of all mothers and children including CSHCN needs in Wisconsin.

Chapter 250 defines the role of the state health officials including the state health officer, chief medical officers, the public health system, the power and duties of the department, qualifications of public health nursing, public health planning, and grants for dental services.

Chapter 251 describes the establishment of local boards of health, its members, powers and duties, levels of services provided by local health departments, qualifications and duties of the local health officer, and how city and county health departments are financed.

Chapter 252 outlines the duties of local health officers regarding communicable disease to include the immunization program, tuberculosis, sexually transmitted disease, acquired immunodeficiency syndrome, blood tests for HIV, and case reporting.

Chapter 253 mandates a state maternal and child health program in the Division of Public Health to promote the reproductive health of individuals and the growth, development, health and safety of infants, children and adolescents. Chapter 253 can be found in its entirety in Appendix A. It addresses:

s. 253.06 State supplemental food program for women, infants, and children
s. 253.07 Family planning (Wisconsin Administrative Code Chapter HFS 151 describes family planning fund allocations).
s. 253.08 Pregnancy counseling services
s. 253.085 Outreach to low-income pregnant women
s. 253.09 Abortion refused; no liability; no discrimination
s. 253.10 Voluntary and informed consent for abortions
s. 253.11 Infant blindness
s. 253.115 Newborn hearing screening
s. 253.12 Birth defect prevention and surveillance system
s. 253.13 Tests for congenital disorders
s. 253.14 Sudden infant death syndrome

Chapter 254 focuses on environmental health and includes health risk assessments for lead

poisoning and lead exposure prevention, screening requirements and recommendations, care for children with lead poisoning or lead exposure, lead inspections, lead hazard reduction, asbestos testing, abatement, and management, indoor air quality, radiation, and other human health hazards.

Chapter 255 addresses chronic disease and injuries and outlines cancer reporting requirements, cancer control and prevention grants, breast and cervical cancer screening programs, health screening for low-income women, tanning facilities, and the Thomas T. Melvin youth tobacco prevention and education program.

TITLE V MCH/CSHCN PROGRAM'S CAPACITY TO PROMOTE/PROTECT THE HEALTH OF MOTHERS AND CHILDREN INCLUDING CSHCN

The Division of Public Health (DPH), Bureau of Community Health Promotion (BCHP), Family Health Section (FHS) is designated as Wisconsin's Title V MCH/CSHCN Program. DPH collaborates with numerous state agencies and private organizations, LHDs, and community providers. Supported by Wisconsin's strong partnerships and sound public health law, the DPH, BCHP, FHS is well-positioned to provide prevention and primary care services for pregnant women, infants, children including CSHCN and their families that are family-centered, community-based, and culturally appropriate.

Federal grants are the primary source of funding for the majority of public health infrastructure, services and activities in Wisconsin. The amount of state General Purpose Revenue (GPR) available to support the Division's capacity for the health of the maternal and child health population, even when state mandates exist, is minimal. Thus we are in constant pursuit of additional grants to enhance our agency's capacity in the area of maternal and child health programming. In addition to the Title V Block Grant, the FHS manages 24 grants that address a range of maternal and child health related-services such as: screening and early intervention enhanced services, injury prevention and surveillance, maternal and child health services and system building including specific CSHCN activities.

/2007/Wisconsin uses a web-based Secure Public Health Electronic Record Environment (SPHERE) for collecting data for MCH, CYSHCN, and Family Planning/ Reproductive Health. SPHERE is used to document and evaluate selected programs in Wisconsin. Public health services provided to individual clients and reported as a snapshot in time. A report based on infant assessments entered into SPHERE tells how many infants are being breastfed, how many are sleeping in the back position, which allows an agency to evaluate services that are being provided and the outcomes of those services. However, it currently does not track or report over time a comparison among those individuals. SPHERE required data is used for reporting the number of unduplicated clients served by the Title V Block Grant and some outcome data about the services those clients. Currently SPHERE is not a statewide MCH surveillance system.

SPHERE is designed as a comprehensive system to document and evaluate public health activities and interventions at the individual, household, community, and system level. The interventions include: Surveillance; Disease and other Health Event Investigation; Outreach; Case-Finding; Screening; Referral and Follow-up; Case Management; Delegated Functions; Health Teaching; Counseling; Consultation; Collaboration; Coalition Building; Community Organizing; Advocacy; Social Marketing; Policy Development; and Policy Enforcement. There are currently 1,169 active SPHERE users representing 150 organizations including all LHDs, Regional CYSHCN Centers, private-not-for profit agencies, and the majority of the tribes. The total number of SPHERE unduplicated clients is 189,550. In 2005, SPHERE was used to document public health activities on 55,588 unduplicated clients including150,982 Individual and 8,607 Community and System Activities.

DPH collaborates with the Bureau of Health Information and Policy, Vital Records to use SPHERE to transmit confidential birth record reports to LHDs. Leveraging the existing security

infrastructure of SPHERE ensured that access to birth records was restricted to only those individuals with assigned permissions and only those records for their particular jurisdiction. In 2005, a governance structure for the DPH Public Health Information Network (PHIN) was established. PHIN consolidates multiple systems into one initiative using a common set of functions. PHIN is the platform for integrated public health data in Wisconsin. In 2006, A PHIN Administrator was hired and a PHIN Lead Team was established comprised of the chair of each of the following PHIN Workgroups: 1) PHIN User Group, 2) Analysis, Visualization, and Reporting (AVR) Core Team, 3) PHIN Communications Group, 4) PHIN Security Group, and 5) Program Area Module (PAM) Integration Team. SPHERE enhancements planned for 2006-2007 include: transfer of data from WIC into SPHERE, birth record reports, testing linkage of SPHERE birth record files and newborn hearing screening, additional reports and screens to support Title V Block Grant Activities, documentation and evaluation in SPHERE for services related to the Milwaukee Home Visitation Program, Medicaid billing, and Oral Health.//2007//

/2008/No significant change.//2008//

/2009/The FHS manages 20 grants addressing MCH services.

SPHERE User groups were established in 5 regions, the MCH Central Office and CYSHCN Regional Centers. The statewide SPHERE lead team has been reactivated. These groups were initiated after two statewide meetings, held in 2007, identified training and SPHERE infrastructure support as system needs. A monthly WISLine web training is held. Other trainings, such as ad hoc reporting, postpartum assessment, are held monthly around the state for SPHERE public and private users. Five regional forums were held last year and are planned for fall 2008 promoting MCH systems and standards of practice. Use of SPHERE data is integrated in the presentations targeted for LHDs and MCH partners.//2009//

STATE PROGRAM COLLABORATION WITH OTHER STATE AGENCIES AND PRIVATE ORGANIZATIONS

Approximately 60% of Wisconsin's Title V funds are released as "local aids" either as a non-competitive performance-based contract to LHDs who have "first right of refusal" or as competitive Request for Proposal (RFP) for specific, statewide or regional initiatives. Five statewide projects will begin July 1, 2005 through December 31, 2010 for services to: improve infant health and reduce disparities in infant mortality; support a genetics system of care; improve child health and prevent childhood injury and death; improve maternal health and maternal care; and create a Parent-to-Parent matching program for families with CSHCN. A new cycle for the Regional CSHCN Centers will begin January 1, 2006 through December 31, 2010 and will be aligned with the six federal core outcomes as part of the President's New Freedom Initiative. In addition, Regional CSHCN Centers will partner in the implementation of Wisconsin's new MCHB funded CSHCN Integration grant. HRSA selected Wisconsin as 1 of 7 Leadership States to help promote the implementation of the six core components of a community-based system of services through the Medical Home concept.

/2007/No significant change.//2007//

/2008/Template objectives are being expanded to assure all state priorities, SPM, NPM, are addressed. Priorities for data collection and evaluation follow the same priorities.//2008//

/2009/No significant change.//2009//

STATEWIDE MCH PROGRAM COLLABORATIONS

Improve Infant Health and Reduce Disparities

Beginning July 1, 2005, the statewide collaborations will focus on the following activities: 1) Support coalition building for the Healthy Babies in Wisconsin initiative, 2) Provide education on evidence-based strategies that improve infant health and reduce disparities in infant mortality, 3) Provide bereavement support services to families and others who are affected by a sudden or unexpected infant death, and 4) Establish a pilot project that supports healthcare providers and community organizations to implement strategies to reduce the risk of SIDS and infant mortality. Project activities are based on a lifespan approach, evidence-based practices identified by Perinatal Periods of Risk data model, recommendations from the Milwaukee FIMR, and core competencies identified for bereavement counseling for SIDS and infant mortality.

/2007/In response to the worsening disparity in Wisconsin between black and white infant deaths, DHFS Secretary, Helene Nelson, named this issue as one of her top priorities and announced a strengthening of efforts to improve the maternal and child health of Wisconsin's racial/ethnic minority populations. From the announcement letter, the department has "joined with partners throughout the state to raise awareness of the racial and ethnic disparities in Wisconsin's birth outcomes. We have learned that racial and ethnic disparities are the consequences of disadvantages and inequities over an entire life course, including the increasing role that stress plays in producing poor outcomes. Intervention strategies are needed that are locally driven and community-based. Research efforts are needed that target differing risk exposures over the entire life course of a woman." The creation of a five-year Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes was announced with a focus on Communication and Outreach, Quality Improvement, Community and Evidence-Based Practices and Data.

Collaborative efforts within DHFS include those with the Medicaid program, and for mental health and substance abuse services, tobacco cessation, and teen pregnancy prevention. Future collaboration is planned through an integrative services initiative within DHFS and in cooperation with the Department of Workforce Development, with an emphasis in Milwaukee. See the website at http://dhfs.wisconsin.gov/healthybirths/ for more information.

The Infant Death Center of Wisconsin (IDC) is the grantee for the Statewide Program to Improve Infant Health and Reduce Disparities. IDC is supporting coalition building for the Healthy Babies in Wisconsin initiative and a Milwaukee Hospital Collaborative to improve perinatal outcomes. Education is provided for WIC, Prenatal Care Coordination (PNCC), and others on the revised recommendations of the American Academy of Pediatric to reduce the risk of SIDS. Bereavement support services include counseling, memorials programs, a family conference, peer parent support, support groups, written information in newsletters and on the web page, and referral to community resources including local health departments. Targeted efforts in the city of Beloit support a community coalition to increase awareness of disparities and provide education and support to African American families with a Community Health Fair and development of a Pregnant Women's Wish List to encourage social support.//2007//

/2008/IDC supported coalitions to host a grand rounds presentation, Creating Smoke Free Environments, and implement Cribs for Kids program. In 2007, the Healthy Babies coalition is collaborating with the March of Dimes and the Association of Women's Health, Obstetric and Neonatal Nurses to plan and sponsor a Prematurity Summit. Education topics focus on preconception health and safe infant sleep practices. In addition to the project in Beloit, a second local coalition was established in the city of Racine.

The 2006 Progress Report on the Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes has been completed and a Statewide Advisory Committee and workgroups have been formed. Please see www.dhfs.wisconsin.gov/healthybirths for updated information on this initiative.//2008//

/2009/IDC collaborated with community groups to produce preconception brochures. In collaboration with AWHONN and DPH, IDC is planning a preconception/prematurity conference. Curricula were developed for middle school students on Safe sleep and

preconceptual health. Through the African American Mother's Wish List, social awareness on supporting pregnant women was increased in Racine, Milwaukee, Kenosha, Dane and Rock counties. The Healthy Natives Babies Consortium was formed to distribute culturally appropriate safe sleep messages.

A revised Framework for Action will be completed in the Summer of 2008. The Statewide Advisory Committee and workgroups continue to meet and are drafting recommendations for DHFS. Collaborative efforts are underway with the University of Wisconsin School of Medicine and Public Health on a Special Funding Initiative to eliminate racial and ethnic disparities in birth outcomes.//2009//

Statewide Genetics System

Beginning July 1, 2005, the new Statewide Genetics System will focus on the following priorities: 1) Establish a genetics advisory committee, 2) conduct comprehensive genetics needs assessment activities, 3) form a genetics specialty care providers network, 4) provide genetics education for providers and consumers, and 5) provide direct clinical genetics services to underserved populations. Project activities are based on recommendations made in the Genetic Services Plan for Wisconsin.

/2007/In July 2005, through a competitive grants process, the Medical College of Wisconsin (MCW) (Dr. William Rhead - Principle Investigator) was selected as the vendor for the Statewide Genetics Systems grant. MCW in turn contracts with the UW-Department of Medical Genetics and the Marshfield Hospital and Clinics to meet the priorities as listed above. The Statewide Genetics Coordinator position funded by the Congenital Disorders Program will take lead responsibility for monitoring implementation of the Wisconsin Genetics Services Plan. With reductions in Title V funding, beginning in 2005 the Teratogen and Stillbirth projects are funded in part by the Wisconsin Birth Defects Prevention and Surveillance Program.//2007//

/2008/In 2006, MCW established the Wisconsin Genetics Advisory Committee to implement recommendations of the "Genetic Services Plan for Wisconsin." Work groups were established to focus on specific priorities and needs. Through Title V funding, MCW and its partners have: provided genetics services through nine outreach clinics for underserved populations, provided clinical services through telemedicine technology, initiated educational programs among primary care medical providers, and promoted the use of genetics services in Wisconsin.//2008//

/2009/In 2007, MCW partnered with the Statewide Genetics Coordinator to complete a needs assessment of clinical genetic services in Wisconsin. Recommendations were made to the Wisconsin Genetics Advisory Council in 2008 to address the shortage of genetic service providers, a lack of funding for genetic services, access to services by underserved populations, and education of primary care providers.//2009//

Improve Child Health and Prevent Childhood Injury and Death

Beginning July 1, 2005, the new statewide collaboration will focus on a statewide system to improve child health and prevent childhood injury and death. This focus relates directly to the State Health Plan, Healthiest Wisconsin 2010, and the Governor's KidsFirst agenda. The program supports all three of the overarching Healthiest Wisconsin 2010 goals (eliminate health disparities, promote and protect health for all, transform the public health system). It specifically supports system priorities for community health improvement processes and coordination of state and local public health system partnerships, and intentional and unintentional injuries and violence. The program promotes the Safe Kids, Strong Families, and Healthy Kids components of Governor Doyle's plan to improve the lives of Wisconsin children, specifically supporting reduction of family violence, ensuring safe routes to school, promoting child transportation safety, connecting families with support services, and improving the child support system.

/2007/The Children's Health Alliance of Wisconsin (CHAW) is the grantee for this Title V MCH program. CHAW is creating a Statewide Injury Prevention Network that will include intentional and unintentional injuries. A website is being developed that will provide a collection of resources, information on prevention strategies, best practice, and a venue to share information between programs. A Summit on Childhood Injury Prevention is planned for October 2006. CHAW is collaborating with the Injury Research Center (IRC) at the Medical College of Wisconsin and the DHFS Injury Prevention Program, to create a Burden of Injury in Wisconsin Report that will include childhood information.

CHAW is partnering with DHFS and the Department of Justice (DOJ) on Child Death Review (CDR) in Wisconsin. They are looking at existing CDR teams and how they function, exploring other communities' interest in CDR and look to develop a model to support new teams. CHAW is taking the lead in the planning of a statewide training for CDR in the spring of 2007.//2007//

/2008/In 2006, CHAW established the web-based Childhood Injury Prevention Network (CIPN), located on their website: www.chawisconsin.org. The announcement and kick-off was held at an Injury Prevention Summit in October 2006. To date, there are 300 participants on the CIPN email list. CHAW worked collaboratively with the DHFS Injury Prevention Program and the Injury Research Center-Medical College of Wisconsin to complete the "Burden of Injury in Wisconsin," which was unveiled at the Summit. The CIPN developed a preliminary strategic plan that will guide and drive the ongoing development and functions of the network. Two pilot Child Death Review Teams were established in Outagamie and Rock Counties. CHAW worked closely with the State Child Fatality Review Team, the Maternal Child Health National Center for Child Death Review and the Michigan CDR Team, to create the "Child Death Review Wisconsin Guide." This guide will be used by new child death review teams as they begin to form and review child deaths.//2008//

/2009/During 2007, two trainings were held to support formation of local CDR teams in Wisconsin. A Partnership Grant from the UW School of Medicine and Public Health was awarded to CHAW to support local team development and mini grants of $5000 will be awarded. The State Title V MCH program funded CDR model program development in 3 counties as part of 2008 performance-based contract and its statewide CDR and Childhood Injury Prevention Network activities. Expansion of CDR teams across the state will continue. In collaboration with the Injury Prevention Program, CHAW assisted in the development and dissemination of the WI Burden of Injury Report.//2009//

Improve Maternal Health and Maternal Care

Beginning July 1, 2005, the new statewide activities will be to: 1) Provide supportive services for the State of Wisconsin Maternal Mortality Review Program, 2) Provide education on evidence-based practices that improves maternal health and maternal care, 3) Promote preconception services for women of reproductive age, and 4) Establish a pilot project that supports healthcare providers to increase risk assessment and follow-up services for women during the preconception, prenatal and interconceptional periods. Project activities are based on a lifespan approach, evidence-based practices identified by the Perinatal Periods of Risk data model, and recommendations from the Milwaukee Fetal Infant Mortality Review.

The DPH implemented the Maternal Mortality Review Program in 2001 to assess, reduce, and prevent pregnancy-associated death among women in Wisconsin by identifying women who died during pregnancy or within one year of termination of pregnancy. Data abstraction is conducted regarding individual and clinical risks, health care utilization, and community services. Case-specific data is summarized and presented to a multi-disciplinary team for a systematic review of important contributing factors amenable to modification or prevention. Through a team process, recommendations are made for policies, services, and programs to improve maternal survival. The work of the Case Review Team was published in the Wisconsin Medical Journal. Pregnancy-related deaths in Wisconsin are generally similar to those of the US population overall and

recommendations include: addressing racial disparities, assuring the performance of autopsies, lifestyle changes related to obesity and smoking, and management of embolic and cardiovascular disease, as well as postpartum hemorrhage.

/2007/The Wisconsin Association for Perinatal Care (WAPC) is the grantee for the Statewide Program to Improve Maternal Health and Maternal Care. WAPC provides education via an annual conference, presentations at other statewide and regional conferences, written materials (position statements, newsletters, resources related to perinatal depression, guidelines for Laboratory Testing in Pregnancy), and web-based learning modules. Strategies to promote preconception services include revising the Becoming a Parent checklist and promotion of folic acid. A pilot project is supporting a health system in the city of Racine to implement postpartum depression screening for mothers in pediatric clinics. WAPC assists with the State of Wisconsin Maternal Mortality Review Program.//2007//

/2008/WAPC supported the Perinatal Foundation's media campaign, Madre, Hay Esperanza (Mother, There is Hope) for educating Latino families about postpartum depression. Preconception resources include a new Prescription for a Healthy Future™ tool, Becoming a Parent materials, and a revised folic acid position statement. The 2006 pilot project supported a health system in the city of Racine to implement postpartum depression screening for mothers in pediatricians' offices. In 2007, healthcare providers in communities with high rates of disparities in birth outcomes will receive a toolkit of strategies to increase screening and follow-up care for the perinatal risk factors of depression and infections.

The State of Wisconsin Maternal Mortality Review Program is planning a report of Pregnancy-Related Mortality in Wisconsin, 2002-2005. WAPC has provided professional education related to recommendations from the case review process including management of hemorrhage, management of depression, care of the obese pregnant women, preconception care, and assessment for domestic violence.//2008//

/2009/WAPC presented the media campaign on raising awareness of perinatal depression for Latino families at 2 national and 3 statewide conferences. In collaboration with WI ACOG, WAPC developed an algorithm and medication chart for the use of antidepressants during pregnancy. The Healthy Birth Toolkit was developed to promote preconception care. A report for the PeriData.Net data system will allow birth hospitals to monitor disparities in birth outcomes.

In collaboration with the State of Wisconsin Maternal Mortality Review Program, WAPC completed a report on Maternal Mortality in WI 1998-2005. Leading causes of death include embolism, hemorrhage, cardiovascular disease and pregnancy-induced hypertension. The report addresses suicide, maternal morbidity, maternal obesity, preconception care and racial disparities.//2009//

Improve Parent Support Opportunities for Families with CSHCN

Wisconsin's CYSHCN Program provides parent support opportunities for families through the five Regional CYSHCN Centers, Parent to Parent and Family Voices. The Regional CSHCN Centers assure all families of CSHCN have access to parent support services. As reported for 2006 in SPHERE, centers referred 68 parents to support groups, provided informal parent matching, referred parents to Parent to Parent and linked with local parent partners including Family Voices to determine and disseminate parent support opportunities. Parent-to-Parent of Wisconsin continues to be funded to provide one-to-one matching for families, train support parents, and seek referrals for new parents who want to be matched. Family Voices works with the CYSHCN Program to disseminate parent support information to parents through a listserv and mailings. Family Voices conducts trainings for parents to enhance their decision making skills and a parent support component is incorporated into these trainings.

/2008/By December 2006 there were 162 families in the Parent-to-Parent database and 165 trained parents with additional trainings occurring throughout 2007. Parent-to-Parent of Wisconsin has outreached to providers including those providing services to children newly identified by the Congenital Disorders Program. In January 2007 Family Voices of Wisconsin was again funded as a Title V statewide initiative to support parent connections and related initiatives. While the regional centers continue to refer families to Parent-to-Parent and link them to support opportunities, Family Voices of Wisconsin provides broad statewide leadership to this effort.//2008//

/2009/By December 2007 there were 190 trained support parents in the Parent-to-Parent database and 78 matches. Parent-to-Parent of Wisconsin translated their curriculum into Spanish, trained non-English speaking support parents and is matching hard-to-reach families in Milwaukee. Family Voices of Wisconsin is funded to build a parent network of informed decision makers, through training, information dissemination and analysis of unmet needs.//2009//

Regional CYSHCN Program Collaborations

The goals of the Regional CYSHCN Centers are to:
• Provide a system of information, referral, and follow-up services so all families of children with special health care needs and providers have access to complete and accurate information.
• Promote a Parent-to-Parent support network to assure all families have access to parent support services and health benefits counseling.
• Increase the capacity of LHDs and other local agencies, such as schools, to provide service coordination.
• Work to establish a network of community providers of local service coordination.
• Initiate formal working relationships with LHDs and establish linkages for improving access to local service coordination.

Each Regional CYSHCN Center has distinct characteristics (located in regional hospital, children's hospital, academic training center, local health department, and family resource center) that collectively present a variety of viewpoints and areas of interest and influence. Currently, Title V block grant dollars are provided to local agencies in nearly every county through contracts with the Regional CYSHCN Centers. The Regional CYSHCN Centers have established a network of active partner parents, many of whom are directly connected to the local health department or other community agency.

The Regional CYSHCN Center model will continuously be refined and focus on the 6 core (national) outcomes.

/2008/Five Regional CYSHCN Centers are in the second year of a five year grant cycle. Core services continue to be information, referral, and follow-up including health benefits services for families and providers. In this grant cycle, there is an increased emphasis on the six NPMs and strengthening CYSHCN collaborations. Regional Centers are actively fostering collaboration with key partners including: cross-referral discussions with Children's Long-Term Care Redesign pilot site; sharing resources with Early Childhood Collaborating Partners (including ECCS); facilitating the spread of Medical Home to local medical practices through the administration of Medical Home Local Capacity Grants and direct team facilitation; offering families with children registered with the Wisconsin Birth Defects Prevention and Surveillance program referral and follow-up services; and cross-referring with WIC nutritionists. While centers continue to provide support to youth and families, parent leadership and support activities are now shared with the statewide Parent-to-Parent of Wisconsin and Family Voices of Wisconsin grants.//2008//

/2009/No significant change.//2009//

Statewide MCH Hotline

Gundersen Lutheran Medical Center-LaCrosse provides services for the Public Health Information and Referral Services for Women, Children and Families (hotline) contract. The contract supports services for three different hotlines that address a variety of MCH issues to include: Healthy Start, Prenatal Care Coordination (PNCC), WIC, family planning, and women's health issues. One hotline, Wisconsin First Step, is specifically dedicated to supporting the needs of the Birth to 3 Program, the Regional CSHCN Centers, and providing information and referral services to individuals, families, or professionals needing to find resources for CSHCN.

In 2004 the MCH Hotline received 8,549 calls; an increase of 516 calls from 2003. Just over 3% of the calls required Spanish translation. The Wisconsin First Step (WFS) Hotline received 2,103 calls in 2004; an increase of 604 calls from 2003. In addition to the toll-free hotlines, the website www.mch-hotlines.org has become a well-utilized resource. In 2004 the website received approximately 35,000 hits to the entire site. A searchable database feature was added to the website in 2003. In addition, in 2004 a pregnancy assessment tool and a user feedback form were added to the website and work has begun to translate the website pages in Spanish.

/2007/The MCH Hotline received 9,025 calls in 2005; an increase of 476 calls from 2004. Approximately 4% of the calls required Spanish translation. The Wisconsin First Step Hotline received 2,185 calls in 2005; an increase of 82 calls from 2004. The website continues to be a well-utilized resource, receiving approximately 37,000 hits to the entire site in 2005. Strategies were evaluated to reach the following priority population callers: Spanish speaking, at risk pregnant women, and homeless individuals and families. This evaluation showed an increase in Spanish speaking callers and callers who were pregnant. The report showed an increase in the number of Prenatal Care Coordination, WIC, Food Share, and Presumptive Eligibility referrals made to callers. 734 hits were documented to the web based pregnancy assessment tool. The homeless population continues to be a challenge to reach.//2007//

/2008/The MCH Hotline received 11,196 calls in 2006; an increase of 2,171 from 2005. In part this increase was due to a back to school ad campaign sponsored by Covering Kids and Families of Wisconsin targeting families in Milwaukee County who may be eligible for BadgerCare. Approximately 4% of the total MCH calls required Spanish translation. The hotline has a contract with Certified Languages International. Most calls are answered in under 1 minute. One staff is bilingual. Inservices for staff have been done providing them with multiple phrases to explain to people they will be connected to the language line for translation assistance. The database provides information for services that are provided in Spanish. The WFS hotline received 2,344 calls in 2006; an increase of 159 from 2005. In 2006, additional tracking component was added to the hotlines' website search engine identifying 112,516 total page views in 2006. The top program areas searched on the website were Birth to 3, WIC, and Prenatal Care Coordination. The site now features a place to download the five regional WFS directories. In September 2006, two education days were held for staff.//2008//

/2009/The MCH Hotline received 8,634 calls in 2007; a decrease of 2,562 calls. No calls were taken for the BadgerCare campaign and there was a change in how calls were logged (see Section IV F). Approximately 4% of the total MCH calls required Spanish translation. The WFS hotline received 1,932 calls in 2007; a decrease of 412 calls. In 2007, a new online directory was added to the website allowing users to generate WFS directories using live data from the hotline database. The top program areas searched for continue to be Birth to 3, WIC, and Prenatal Care Coordination. Results of a 4th Quarter automated survey shows 99% of 87 MCH respondents felt they had been heard/supported by the I&R Specialist and 100% for 11 WFS respondents.//2009//

OTHER KEY STATE COLLABORATIONS

Reproductive Health Services

In 2004, the DHFS established a Family Planning and Reproductive Health Council. Its role is to provide advice to the Secretary and foster internal Departmental coordination to insure access to cost-effective family planning services and reproductive health care. Through this Council, collaboration among the MCH's Family Planning Program, the Wisconsin Medicaid Program (which administers the Medicaid Family Planning Waiver), and external health care providers has significantly increased. As a result of this collaboration we have seen the Family Planning Waiver become successful in Wisconsin. Through December 31, 2004, 55,515 women were enrolled; representing approximately 17% of the estimated Waiver eligible population.

/2007/No significant changes.//2007//

/2008/As of December 31, 2006, 62,935 women were enrolled in the Family Planning Waiver, representing approximately 22% of the estimated Waiver eligible population. Wisconsin will submit a renewal application for the Medicaid Family Planning Waiver in 2007. The Waiver has created new opportunities for collaborations, resulting in increased access to services.//2008//

/2009/The Family Planning Waiver was renewed January 1, 2008 for 3 years.//2009//

MCH Advisory Committee

The MCH Advisory Committee consists of about 40 diverse members representing various backgrounds who come together on a quarterly basis for the purpose of advising the Division of Public Health on important maternal and child health issues as requested. The meetings provide the members with current information, encourage sharing and networking of pertinent information, and the opportunity to discuss issues related to the MCH program. Its diverse membership fosters the development of informal relationships with representative of a broad range of entities. Membership includes parents, and representatives of local health departments, nonprofit agencies, tribal agencies, and academic institutions.

In 2004, the MCH Advisory Committee identified Early Childhood Comprehensive Systems. Members were briefed on state and national ECCS efforts and activities. Committee comments were solicited on the year-one progress report and year-two plan.

/2007/Over the past year, the MCH Program Advisory Committee has engaged in dialogue and focus group activities on mental health topical areas such as infant mental health, depression across the lifespan, and mental health in the workplace, with a goal to help infuse mental health into public health practice within the MCH/CYSHCN Program and partnerships. The MCH Program Advisory Committee will be addressing several of the policy recommendations as outlined in the Lieutenant Governor's Task Force on Women and Depression in Wisconsin Report-May 2006 www.ltgov.state.wi.us.//2007//

/2008/Continuing the focus on mental health, the MCH Program Advisory Committee created a joint statement titled "A Foundation for Collaboration between DPH and the Division of Mental Health and Substance Abuse Services (DMHSAS)". This statement emphasizes the integration of mental, physical, social, emotional and spiritual health for all persons. In addition an "Action Guide Addressing Mental Health" was developed by MCH Advisory Committee and the state divisional staff. This guide focuses on the areas of Businesses/Workplaces Schools and Child Providers Infant-Age 18, Technical Colleges/Colleges/Universities, Communities and Other Providers, and Strengthening State Government's Role in Developing MCH and Mental Health Linkages. The process and products were displayed via a poster session at the Wisconsin Public Health Association/Wisconsin Association of Local Health Departments and Boards Annual Meetings and both organizations have agreed to endorse the statement and to review the Action Guide to determine what specific steps they may take in the local counties. Additional plans include a wider dissemination of the Joint Statement and Action Guide as well as presentations during the 5 MCH Regional forums to be held during the spring and summer.//2008//

/2009/The MCH Advisory Committee worked to move the Joint Statement and Action Guide from an MCH Advisory Committee document to a high level enterprise policy document within DHFS entitled "The Integration of Physical Health, Mental Health, Substance Use and Addiction". Endorsed by the DHFS Secretary and all Divisions, the Joint Statement and Action Guide provide a conceptual framework for systematic changes and call to action in our communities. This Document will move forward for endorsement by other Departments. The MCH Advisory Committee will be part of the Healthiest Wisconsin 2020 process to assure MCH objectives are outlined within the new state health plan.//2009//

C. Organizational Structure

On January 6, 2003, Jim Doyle was sworn in as Wisconsin's 44th Governor. Concurrently, Barbara Lawton was sworn in as Wisconsin's first female elected Lieutenant Governor. Through her work, such as her Wisconsin Women = Prosperity initiative, she has championed women's health issues.

Prior to serving as Governor, Mr. Doyle was the state Attorney General for 12 years and known as a national leader in the fight to improve public health through his successful lawsuit against the tobacco industry. Today, Governor Doyle considers children a high priority. In order to invest in Wisconsin's future he developed an ambitious initiative known as the KidsFirst Agenda. Governor Doyle believes "that the single most important thing we can do today to ensure a strong, successful future for Wisconsin is to invest in our kids early … because what we do now will determine what kind of state Wisconsin will be 10, 20, even 50 years from now" (KidsFirst 2004). KidsFirst has four parts: Ready for Success; Safe Kids; Strong Families; and Healthy Kids. We are working to implement the Governor's KidsFirst effort which will contribute to improving the health of children by:

- Providing all children with health care coverage
- Improving oral health care
- Immunizing children on time
- Serving kids a healthy school breakfast
- Ensuring eligible families receive food stamps
- Teaching children fitness and nutrition for life
- Reducing youth smoking
- Stepping up efforts to reduce teen pregnancy
- Reducing children's exposure to lead paint
- Helping kids with asthma
- Giving infants a healthy start
- Promoting early childhood mental health

A copy of the publication can be found at www.wisgov.state.wi.us.
In July 2004, the DHFS Secretary implemented the Public Health Restructuring Plan with the purpose to focus and streamline the role of state government to: improve state agency operations and to free up resources to invest in local government and other public health partners and shift some regulatory and case specific services to the local level where they can be performed more efficiently and effectively.

Governor Doyle named Helene Nelson as the Secretary of the Department of Health and Family Services. She is an experienced executive in state and county government and served under four different governors as Deputy Secretary or Chief Operating Officer for five state agencies: Revenue; Transportation; Health and Social Services; Industry, Labor and Human Relations; and Agriculture, Trade and Consumer Protection. In April 2005, Roberta Harris was appointed as the Deputy Secretary and will serve as chief operating officer for the Department overseeing internal management on behalf of the Secretary. She is recognized as a highly effective leader in the Milwaukee community and will be sharing her time between Madison and Milwaukee focusing on the Governor's KidsFirst agenda.

There are five major divisions and two offices in the Department of Health and Family Services. Official and dated organizational charts are on file in the state office and available on request or accessible via the website at www.dhfs.state.wi.us/organization/dhfs/functions.pdf. A brief summary of each division/office follows.

The Office of Legal Counsel (OLC) is an office within DHFS which serves the Secretary and acts as a resource for the Department as a whole. The mission of OLC is to provide effective and accurate legal services and advice to the Department.

The Office of Strategic Finance (OSF) provides department wide planning, budgeting, evaluation and county/tribal liaison services.

The Division of Management and Technology (DMT) provides management support for fiscal services, audit, information technology, personnel, affirmative action and employment relations.

The Division of Children and Family Services (DCFS) focuses on issues, policies and programs affecting children and families from a social service perspective, and has the responsibility for the regulation of the child welfare programs.

The Division of Disability and Elder Services (DDES) is responsible for 1) long term support for the elderly and people with disabilities including the Birth to Three Program, 2) mental health and substance abuse services and 3) regulation and licensing.

The Division of Health Care Financing (DHCF) is responsible for administering the Medical Assistance (Medicaid), Food Share, Chronic Disease Aids, Health Insurance Risk Sharing Plan (HIRSP) and General Relief programs.

The Division of Public Health (DPH) is responsible for providing public health services, and environmental and public health regulation. The Division has programs in the areas of environmental health; occupational health; family and community health including injury prevention, emergency medical services, chronic disease prevention and health promotion; and communicable diseases. It is also responsible for issuing birth, death, marriage and divorce certificates as well as collecting statistics related to the health care industry and the health of the people in Wisconsin. Coordination and collaboration with other DHFS divisions and within DPH's bureaus is expected and regular, especially for particular programs and topic areas such as CSHCN, teen pregnancy prevention, STIs, tobacco use, child abuse prevention, etc.

On July 11, 2005, Dr. Sheri Johnson assumed the position as Division of Public Health Administrator. Dr. Johnson holds a M.A. and Ph.D. in Clinical Psychology from Boston University with clinical fellowship experience from Harvard Medical School. Her interests and experiences include trauma, HIV/AIDs, foster care, and community influences on child and adolescent development. She has conducted research on addressing racial disparities and assuring cultural competence in health care.

With the restructuring completed in July 2004, five bureaus were formed (reduced from six bureaus) within the DPH:

The Bureau of Community Health Promotion (BCHP) has a primary responsibility to provide a statewide model of integrative public health programming across the life span. The Bureau has key relationships with local health departments, community-based organizations, private voluntary organizations, and academic and health care provider networks.

The BCHP contains four organizational sections: Family Health; Nutrition and Physical Activity; Chronic Disease and Cancer Prevention; and the Tobacco Prevention Program. The BCHP has over 100 employees, doubling in size as two bureaus merged together as part of the restructuring plan.

Within the BCHP, the Family Health Section has responsibility for the Title V Program and to improve the health of women, infants, children including Children with Special Health Care Needs Program (CSHCN), teens, and families as they progress through the critical developmental milestones of life. A major emphasis of the programs within the Family Health Section involves prevention (including injury prevention and sexual assault prevention), early screening, and early intervention. Examples of the continuum include newborn screening, universal newborn hearing screening, early identification of pregnancy, and breast and cervical cancer screening. A more detailed description is found in Section D.

See Attachment for Section III. C. - Organizational Structure (Family Health Section Org Chart).

The Nutrition and Physical Activity Section has responsibility for a variety of public health nutrition education and food programs. WIC (The Special Supplemental Nutrition Program for Women, Infants and Children) and WIC FMNP (Farmers' Market Nutrition Program) provide both supplemental nutritious foods and the critical nutrition information needed for healthy growth. TEFAP (The Emergency Food Assistance Program) and CSFP (Commodity Supplemental Food Program) provide USDA commodity foods to low income families. Several nutrition education programs such as the Nutrition and Physical Activity Program, 5 A Day for Better Health, and the Food Stamp Nutrition Education Program to promote healthy eating and physical activity for good health. The Section is also responsible for addressing food insecurity and hunger.

The Chronic Disease and Cancer Prevention Section has responsibility to plan, promote, implement, and evaluate comprehensive population and evidence-based programs using best practices in the following areas: Diabetes Prevention and Control, Cardiovascular Health, Arthritis Prevention and Control, and Comprehensive Cancer Prevention and Control.

The Tobacco Prevention Section has responsibility to reduce tobacco use and exposure in every Wisconsin community. This is accomplished through programs that use best practices to prevent the initiation of smoking by youths and adults, promoting treatment for persons with tobacco-related addictions, and protecting all residents from exposure to environmental smoke.

The Bureau of Communicable Diseases and Preparedness is responsible for the prevention and control of communicable diseases in Wisconsin and for ensuring that the public health and hospital systems are fully prepared for bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.

The Bureau of Environmental and Occupational Health promotes public health through statewide programs to increase public awareness of environmental and occupational health hazards and disease and works to prevent and control exposure to environmental and occupational health hazards.

The Bureau of Health Information and Policy's primary responsibilities are to: collect, maintain and provide vital records for the citizens of the state; integrate and manage major public health related information systems; collect, protect, disseminate and analyze health care and population-based health data needed to conduct critical state business; and support a division-wide planning and policy focus on population health that will result in achieving the goals set out in the state health plan, Healthiest Wisconsin 2010.

The Bureau of Local Health Support and Emergency Medical Services has a primary responsibility to build partnerships and to provide leadership and support through the development and recommendations of statewide policy related to the Wisconsin Public Health System and emergency medical services community.

The Regional Offices of the Division of Public Health primarily function as information pipelines through which central office and local health departments communicate.

/2007/ The FHS no longer has responsibility for the breast and cervical cancer screening program known as WWWP but remains within our Bureau. //2007//

/2008/ In November 2006, Jim Doyle was reelected and in January 2007 sworn in as the 45th Governor of Wisconsin. Concurrently Barbara Lawton continues as Lt. Governor. Through her ongoing work, such as the Lt. Governor's Task Force on Women and Depression in Wisconsin Report, May 2006 (http://www.ltgov.state.wi.us), she continues to champion women's health issues which have strengthened MCH's collaboration with Mental Health.

Secretary Helene Nelson retired from the DHFS in November 2006. Kevin Hayden, Division of Health Care Finance Administrator at DHFS was appointed as the new DHFS Secretary effective January 2007.

In April 2007, the Division of Disability and Elder Services was separated creating the Division of Mental Health and Substance Abuse Services, the Division of Long Term Care, and the Division of Quality Assurance. Further DHFS changes included restructuring and renaming the Division of Management and Technology and the Office of Strategic Finance. The Division of Management and Technology is renamed the Division of Enterprise Services, and the Office of Strategic Finance is renamed the Office of Policy Initiatives and Budget. //2008//

/2009/ In April 2008, Secretary Hayden stepped down to return to the private sector. Karen Timberlake was appointed as new Secretary for DHFS. On June 6, 2008, Dr. Sheri Johnson, DPH Administrator left her post. Tom Sieger, Deputy DPH Administrator will be interim Division Administrator until her position is filled. As of July 1, 2008 DHFS will be split into two departments--Department of Children and Families (Reggie Bicha, Secretary) and Department of Health Services (Karen Timberlake, Secretary). The MCH Program will remain within the Department of Health Services, with the exception of one position that was responsible for monitoring the Home Visitation Programs of Family Foundations and Empowering Families of Milwaukee. The position, but no MCH funding, will be going to the Department of Children and Families. There will be five Divisions in the new Department of Health Services: Divisions of Public Health, Long Term Care, Mental Health and Substance Abuse, Quality Assurance, and Medicaid. //2009//
An attachment is included in this section.

D. Other MCH Capacity

/2007/ Wisconsin's current Title V MCH Block Grant award is $10,919,759. This is Wisconsin's smallest grant award since 1993! Beginning in 1995, the Wisconsin's Title V MCH Block Grant award has steadily declined (except for slight increases in 1999, 2000 and 2002 of 1 - 2%). In 2004, we experienced our biggest Title V cut EVER of 5.44% ($-648,146) with another significant cut in 2006 of 2.67% ($-299,935). To address the MCH budget reductions, the Department cut state operations by 19% by 2007. During SFY 05, Title V MCH Block Grant supported 46.99 FTEs. For SFY 07, the Grant supports a total of 37.04 FTEs. We have eliminated 9.95 FTEs, but the workload and needs continue. Following is an update of positions that are authorized and funded, respectively, by Wisconsin's Title V MCH Block Grant.

On May 1, 2006, the BCHP implemented a minor organizational realignment. The BCHP Office has nine staff of which 7.0 FTEs are authorized and funded at some level with Title V funds. (The first number represents the position authority and the number in ( ) represents the amount that is charged to Title V funds.) The Bureau Office consists of the: Bureau Director 1.0 FTE (.25 charged to Title V) Susan Uttech; Chief Medical Officer 1.0 FTE (.75) Murray Katcher; Chief Dental Officer 1.0 FTE (1.0) Warren LeMay ; CYSHCN Medical Director .75 FTE (.75) Sharon Fleischfresser; Health Education Specialist .80 FTE (.80) Mary Gothard; Program Director for Disparities in Birth Outcomes 1.0 FTE (1.0) Patrice Onheiber; State Dental Hygienist Officer 1.0 FTE (1.0) Vacant; and Bureau Office Manager .45 FTE (.45) Debbie Hess. In addition, the Youth

Policy Director, Claude Gilmore, is located in the BCHP Office but the position authority and funding support is from CDC's Comprehensive School Health Program.

The Family Health Section (office) consists of fourteen staff of which 6.0 FTE are supported with Title V MCH Block Grant funds: Family Health Section Chief 1.0 FTE (1.0) Linda Hale; MCH Unit Supervisor 1.0 (1.0) Vacant; Grants Coordinator 1.0 FTE (1.0) Jayne McCredie; Office Assistant 1.0 FTE (1.0) April Spores; SPHERE Data Consultant 1.0 FTE (1.0) Susan Kratz; and Injury Prevention Consultant 1.0 FTE (1.0) Vacant. The other FHS positions include: SSDI, Organ and Tissue Donor, EMSC, Sexual Assault Prevention, Injury Surveillance, and three contracted positions for Injury, Congenital Disorders, and Genetics.

The MCH Unit (which includes the CYSHCN Program) has 17 staff of which 11.0 FTE are supported with Title V MCH Block Grant funds to include: 4.0 FTE Public Health Nurses who address: maternal and perinatal health; infant and young child health; child health; adolescent health; and children and youth with special health care needs; 3.0 FTE Public Health Educators who address: women's health, reproductive health and family planning; school-age and adolescent health, and children and youth with special health care needs; 2.0 FTE Epidemiologists (one who is dedicated to the MCH Program and one who is dedicated to the CYSHCN Program) 1.0 FTE Audiologist; and 1.0 FTE Office Assistant. The remaining MCH Unit staff include: the Abstinence Consultant, ECCS Coordinator, WE-TRAC Project Manager, and two CYSHCN contracted positions.

The remaining 13.04 FTEs funded with Title V funds within DPH are:
• .32 FTE publications coordinator in the Nutrition and Physical Activity Section
• .70 FTE Lead Prevention Consultant in the Bureau of Environmental and Occupational Health
• 1.1 FTE Fiscal Grants Managers in the Office of Operations
• 1.0 FTE Policy Coordinator in the Bureau of Health Information and Policy
• 9.92 FTE that provides partial infrastructure support for staff time of regional office directors, nurse consultants, health educators, and nutritionists. //2007//

/2008/ Wisconsin's current Title V MCH Block Grant award is $10,919,759. For SFY 08, the Grant continues to support a total of 37.04 FTEs. Following is an update of positions that are authorized and funded, respectively, by Wisconsin's Title V MCH Block Grant.

The 13.04 FTEs funded with Title V funds within DPH remain the same. There are 9 vacant positions, 5 that are MCH funded within the Family Health Section. All five are in process of being filled with the intent to have this accomplished by mid November.

The BCHP Office continues to have nine staff of which 7.0 FTEs are authorized and funded at some level with Title V funds. The only change from SFY 2007 is that Lisa Bell was hired as the State Dental Hygienist Officer filling the 1.0 FTE vacancy in March 2007.

The Family Health Section (office) consists of 18 staff which 7.0 FTE are supported at some level with Title V MCH Block grant funds. The 1.0 FTE MCH Unit Supervisor vacancy was filled by Terry Kruse in November 2006.

The MCH Unit (which includes the CYSHCN Program) continues to have 13 staff of which 10.0 FTEs are supported with Title V MCH Block Grant funds. The MCH Unit Abstinence Consultant position (1.0 FTE) not funded by the Title V MCH Block Grant has been vacant since February 2007. This position will not be filled because Wisconsin has decided to not accept future federal abstinence funds. This decision was related to the changes that have occurred over time. We have accepted federal abstinence education funds every year since 1997. In the past, grantees were allowed to implement select elements of the abstinence program. Now grantees must strictly adhere to all eight elements in the definition of abstinence education specified in Title V of the Social Security Act. If federal requirements are modified in the future, the State would reconsider an application for abstinence education funds. //2008//

/2009/ Wisconsin's current Title V MCH Block Grant award has been cut by $120,872 and is now $10,800,119.

For SFY09, the Grant supports 36.14 FTE (down 1 FTE in the MCH Unit due to Home Visiting Program going to new Department; no Title V monies will be going with the position).

Within DPH, the same 13.14 FTES from 2008 are funded through Title V funds.

A total of 10.02 FTEs support the work done in the five health regions. This is an increase of .1 (from 13.04 in 2007-2008 to 13.14 in 2008-2009) will be going to the Western Regional Office to assist in the support of the CYSHCN Nutrition Network activities.

The BCHP Office has nine staff of which 7.0 FTEs are authorized and funded at some level with Title V funds.

There are a total of 16 FTEs between the Family Health Section office (6.0) and MCH Unit (was 11 but now is 10 because of the development of the new Department of Children and Families).

There is currently one vacant position within the Family Health Section, Program Support/Human Services Coordinator. Due to the cut in the block grant funding, it is the program's intent to not fill this position at this time. //2009//

E. State Agency Coordination

COORDINATION OF TITLE V MCH/CYSHCN PROGRAM WITH EPSDT, WIC, TITLE XIX, AND BIRTH TO 3

Prenatal Care Coordination

Title V supports the Medicaid Prenatal Care Coordination (PNCC). PNCC helps pregnant women gain access to medical, social, educational, and other services related to pregnancy. Services are available to Medicaid-eligible pregnant women, at risk for adverse pregnancy outcomes, through 60 days following delivery. Infants are referred for EPSDT services.

Many PNCC providers participate in the First Breath Program of WI Women's Health Foundation (WWHF). First Breath provides education, support, and resources to help pregnant women quit smoking. Some LHDs use Title V funds to provide similar services to women who not eligible for PNCC.

/2007/ A new PNCC assessment tool was implemented. Training was provided on the new tool, PNCC data, SPHERE, and outcomes including perinatal depression, spacing pregnancies, and safe infant sleep. The My Baby and Me program was piloted with PNCC providers to address alcohol use of pregnant women. MCH helped DHFS evaluate the Medicaid PNCC benefit. //2007//

/2008/ Collaboration with My Baby and Me was a presentation at a fall statewide family planning meeting about preconceptional counseling and screening for substance use. Recommendations from the evaluation to improve PNCC were implemented by the MCH program to support quality improvement. A nationally recognized curriculum, Great Beginnings Start Before Birth, was identified to highlight strategies for psychosocial support and to engage and retain clients. Other perinatal trainings are available via web cast. Activities to implement outcomes for the PNCC benefit using regional provider groups were: data collection on key outcomes, identifying benchmarks, and sharing successful improvement efforts.

A pilot project, Women's Health Now and Beyond Pregnancy, focuses postpartum services on interconception services: distributing emergency contraception and dual protection supplies; assuring access to continuing family planning supplies and services; assuring enrollment in the Family Planning Waiver or other Medicaid; distributing multivitamins containing folic acid; and promoting women's health. //2008//

/2009/ A research project found reductions in LBW, VLBW, preterm birth and NICU admissions for infants of women receiving PNCC. The MCH program offered PNCC trainings at northern LHD and tribal sites. Regional PNCC provider groups offer a forum for education on best practices and desired outcomes. Great Beginnings Start Before Birth training was offered and additional trainings are planned. The Women's Health Now and Beyond Pregnancy pilot project was implemented by 5 PNCC programs. //2009//

Birth to 3 Program

The Part C early intervention program, Birth to 3 (B-3), is located in the DDES Children's Services Section. This Section administers the Children's Long-Term Care redesign and waiver programs, and Family Support. CYSHCN works with DDES. WI Sound Beginnings has integrated Early Hearing Detection and Intervention (EHDI) programming with B-3 services. MCHB funds are given to the B-3 Program to improve services for children who are deaf and hard of hearing. CYSHCN/ B-3 developed and implemented the use of a nutrition screening tool to promote early identification of nutrition needs. Joint surveys and communication are developed to inform health care providers about Part C and Title V services. CYSHCN and B-3 pooled resources to fund First Step, a 24/7 toll free hotline (includes TTY and language line) and website for parents and providers of children and youth with special health care needs. Per statute, B-3 staff is appointed by the DHFS Secretary to serve on the Birth Defect Prevention and Surveillance Council.

CYSHCN staff is on the State's B-3 Interagency Coordinating Council, Children's Long-Term Care Committee and B-3 Autism Services workgroup on policies and practice standards. CYSHCN staff co-leads the annual Circles of Life Conference for families of CYSHCN with B-3 Staff.

/2007/ The Birth Defect Prevention and Surveillance Council provide input to B-3 on Eligibility and Diagnosed Conditions and Atypical Development document. //2007//

/2008/ No significant change. //2008//

/2009/ CYSHCN staff and contracted partners attend B-3 regional forums and in-services to provide updates and encourage interagency referrals. //2009//

HealthCheck -Wisconsin's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

HealthCheck promotes early detection and treatment of health conditions associated with chronic illness and disabilities in children. Health exam for children include growth, development, hearing and vision checks, immunizations, and a complete physical exam. Since 1992, exams have increased from 27% to 71% because of the Medicaid Managed Care program. WI Medicaid data has shown children in HMOs are more likely to receive a HealthCheck exam than children in fee-for-service systems.

/2007/ In 2005, 337,533 health exams were performed; the exam rate increased to 86%. In October 2005, a HealthCheck Statewide Training Session was held with 150 attendees. //2007//

/2008/ In 2006, 352,884 health exams were performed; the exam rate increased to 88%. //2008//

/2009/ In 2007, 359,491 health exams were performed; maintaining an exam rate of 88%. //2009//

Coordination with Family Leadership and Support

MCH staff partner with Family Leadership and Support Programs/Initiatives to develop, plan and implement activities for families. Coordination occurs with parent organizations such as WI Family Voices, WI Family Ties, FACETS, Parents as Leaders and Parents in Partnership Training Initiative, Family Action Network and the Parent-to-Parent Matching Program.

/2007/ In 2006 CYSHCN support was given to the Circles of Life Conference for families of children with disabilities. //2007//

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

Relationship with Mental Health

The Injury Prevention Program (IPP) works closely with the Bureau of Mental Health and Substance Abuse (BMHSA), Mental Health Association of Milwaukee County, and county and local mental health professionals on suicide prevention across the life span. The IPP leads monthly meetings of the Suicide Prevention Initiative (SPI).

An Internal MH/AODA Coordination Committee formed in February 2005 meets quarterly. This committee is co-chaired by the Director of BMHSA and DHFS Youth Policy Director with membership from education, public health, and mental health/substance abuse divisions. The purpose is to improve inter-divisional and interdepartmental communication and coordination.

In 2005, MCH established a State Bullying Prevention Planning Committee. Members are from public education, public health, medical schools, media, and local community agencies. Activities include public awareness campaign, listing of current state and local best practices, establishing statewide network information sharing, exploration of policy and legislation strategies, and link to the Healthiest WI 2010 State Health Plan.

/2007/ The SPI works with the statewide Crisis Network comprised of county crisis teams. SPI representatives attend the network's quarterly meetings. IPP staff participates on the planning of the DHFS Crisis Conference.

The MCH Program Advisory Committee engaged in discussion of infant mental health, depression across the lifespan, and mental health in the workplace, with a goal to help infuse mental health into public health practice within the Title V Program and partnerships. The Committee will address policy recommendations in the Lieutenant Governor's Task Force on Women and Depression in WI Report-May 2006 www.ltgov.state.wi.us.

The CYSHCN Health Promotion Consultant participates on a DPI workgroup on school curriculum for middle school children on mental health disorders; part of the anti-stigma objective from the WI United for Mental Health initiative. The curriculum complements the Suicide Prevention Curriculum. //2007//

/2008/ Working with the Division of Mental Health and Substance Abuse (DMHSA), MCH staff serve on mental health workgroups: WI United for Mental Health; Workgroup to establish a crosswalk and billing system for Medicaid infant mental health service providers; Inter-Intra-Departmental Adolescent Treatment Focus Group; Seclusion and Restraint Workgroup; Children and Youth Sub-Committee of the Mental Health Council; Mental Health in Primary Care; Infant Mental Health workgroup; and the WI Infant and Early Childhood Mental Health Steering

Committee. CYSHCN Regional Centers systems change grants on Medical Home practices is focusing on children with mental health issues. SPI continues with involvement from staff from the MCH program, IPP, DMHSA, DPI, HOPES (Helping Others Prevent and Educate about Suicide), Mental Health Association of Milwaukee, and Department of Corrections. //2008//

/2009/ The MCH Advisory Committee is working to infuse mental health into public health practice within MCH Programs. The Integration of Physical Health, Mental Health, Substance Use, and Addiction Initiative will be launched in 2008. The Infant Mental Health Steering Committee produced the 2007 Annual Report and Fact Sheet for the Leadership Team. The report will be forwarded to the Governor's Office. The Division of Mental Health has engaged all DHS Divisions in a mental health transformation initiative using Pubic Health principles and processes with a goal to eliminate seclusion and restraint for children in day treatment settings, group homes, out-of-home placement, and foster care settings. CYSHCN staff provides consultation. WI United for Mental Health received a Healthier Wisconsin Partnership Grant to address mental health stigma in minority populations. LHDs recruit women for focus groups to get information from minority women about stigma within their environment and culture. //2009//

Relationship with Social Services and Child Welfare

There are 72 public child welfare programs with services provided by county human or social service departments and the Bureau of Milwaukee Child Welfare in Milwaukee County. Eleven Indian tribes each provide child welfare services. The Division of Children and Family Services (DCFS) is the state child welfare agency that supervises the delivery of child welfare services of counties. WI provides approximately half of the funds for child welfare services and the counties provide the remaining.

WI's Child Welfare Program Enhancement Plan (PEP) is a two-year plan to implement system-level change designed to achieve the newly established federal standards for child protection. It promotes collaboration to establish and implement best practices.

The MCH program maintains working relationships with DCFS and county social services to prevent child maltreatment and promote the health and well being of children in out-of-home placement. MCH works to promote evidence-based, home visiting programs in 10 sites across the state and in Milwaukee County and collaborates with the University of WI-Extension to provide quality training for local staff providing home visiting.

/2007/ WI's Children's Trust Fund, with Prevent Child Abuse WI and Child Abuse Prevention Fund of Children's Hospital and Health Systems presented the State Call to Action to End Child Abuse and Neglect: WI's State Plan to Prevent Child Maltreatment, to DHFS Secretary on February 6, 2006. Recommendations in the State Plan will be used to advise MCH programs including home visiting and efforts to reduce infant mortality. //2007//

/2008/ The Governor proposes a Department of Children and Families (DCF) to strengthen the system of services for children and families. DCF will unify programs from DHFS and DWD that serve the social and financial needs of children and families. This assures WI children have opportunities to grow up safe, healthy, and successful in strong families by consolidating programs to strengthen access to and coordination of services to they need. The Governor proposes to implement universal home visiting to all new first-time parents and expand targeted home visiting to parents at-risk of child maltreatment. Improvements to child welfare are: increase the foster care rate, fully fund projected caseloads in Milwaukee County programs, and welfare program staff recruitment and retention. //2008//

/2009/ DCF was created with the passage of the budget combining the TANF program, W-2, and the state child welfare systems. On July 1, 2008, the DPH home visiting programs, Family Foundations and Empowering Families of Milwaukee, will be administered by DCF.

During transition MCH will continue connections with the DCF and focus on sustaining program integrity and quality to avoid disruption of services. //2009//

Relationship with Education

CYSHCN staff serves on the advisory board of the WI School Parent Educator Initiative that promotes parent involvement in the education system for students with disabilities.

DPI received a 5-year State Improvement Grant and developed the WI State Improvement Plan for Children with Disabilities to improve state systems providing early intervention, education, and transition services to families and children with disabilities. CYSHCN staff serve on the State Improvement Grant Steering Committee. Parts of this plan enhance the ECCS Grant.

DPH staff was appointed to serve on DPI's Advisory Council for Alcohol and Other Drug Abuse Programs effective August 1, 2005 through August 1, 2008. Staff serve on DPI's WI Afterschool Network and Oversight Work Group.

/2007/ IPP has been working with DPI in the statewide SPI. DPI participates in the monthly SPI meetings. DPI provided support to the EMSC and Injury Prevention Annual Conference, Childhood Emergencies: Prevention and Management. DPI is on the Injury Coordinating Committee, a statewide advisory group that meets quarterly.

DPI and DHFS/DPH implemented a joint strategic plan to promote Comprehensive School Health Programs to increase coordination between LHDs and local school districts. There is joint departmental collaboration on the Governor's School Health Award, reapplication for the 2008 CDC-CSHP five year competitive reapplication state grant, the Abstinence Supplemental Grant, support of a WI Sexual Risk Behavior's Data website; the statewide adolescent health Listserv; youth listening sessions; and review of STD data and infrastructure. //2007//

/2008/ DHFS and DPI will establish a new Memorandum of Agreement (MOA) on a broader array of programs beyond physical activity, nutrition, tobacco, and childhood obesity. DHFS works closely with DPI, WPHA and the WALHDAB to conduct a statewide analysis of school health services. Progress continues to be made on a joint DHFS-DPI asthma management initiative in schools: the WI Association of School Boards, and the WI Association of School District Administrators. //2008//

/2009/ DHS and DPI established an MOA highlighting coordination with food safety, childhood lead, diabetes, alcohol and other drug abuse, mental health, unintentional and intentional injury programs with data sharing through 2012. In partnership with DHS, DPI obtained a five year, $3.5 million grant from CDC, to support efforts to promote physical activity, nutrition, and coordinated school health programs, to prevent HIV and tobacco use and to conduct the Youth Risk Behavior Survey. DHS will convene an Expert Policy Panel for DPI to meet requirements from the Center for Best Practices Healthy Kids, Healthy America Grant.

DPI receives ECCS grant funds for Regional coach activities. CYSHCN staff provide consultation to two new DPI initiatives: 1) a 5 year state Improvement Grant for a teacher/personnel development plan and other DPI special education goals; and 2) Response to Intervention initiative to enhance math, reading and social-emotional development for students in special education and change school culture for all students. //2009//

Relationship with Early Childhood Comprehensive Systems

Receiving the Early Childhood Comprehensive Systems (ECCS) grant increased MCH state-level capacity and focus on the early childhood years. The long term objective of WI's ECCS Project

focused on a major systems and infrastructure realignment. Under MCH leadership in the last 18 months a shift toward greater communication has evolved among stakeholders from the five ECCS component areas, with a growing interest in systems integration for young children and their families.

/2007/ Four goals have been embraced by stakeholders in early childhood with specific strategies being developed promoting cross systems integration as part of the ECCS Implementation Plan to support stronger collaboration with many partners interested in positive outcomes for young children and their families. //2007//

/2008/ No significant change. //2008//

/2009/ In June 2007 the MCH program contracted with WI Alliance for Infant Mental Health to lead state efforts to increase systems coordination and advance the ECCS implementation plan. The MCH Infant/Child Health Consultant monitors this contract and joined the State ECCS Action Team. //2009//

Relationship with Department of Justice

The Department of Justice (DOJ) is a member of the IPP's CDC grant, WI Violent Death Reporting System Technical Advisory Board (TAB). DOJ manages the state's Child Death Review Team. Membership includes the MCH Chief Medical Officer and DPH staff.

/2007/ The IPP began work with DOJ in their development of CASEPOINT, a real time web based reporting system for Coroners and Medical Examiners. Data elements needed by DOJ were included. //2007//

/2008/ No significant change. //2008//

/2009/ A CDR manual was developed by CHAW with Title V support and 2 trainings for local teams were held. A DUA was signed between DHS-Injury Prevention Program and MI Institute of Public Health for the State's CDRT to promote a standardized data collection tool and a state and national data system. Trainings for local teams began. The State team is exploring alternatives for location of this team, legislation and models of other states, and sustainability of CDRTs at a local level.

DOJ participates on the WVDRS TAB.

The Sexual Assault Prevention Program (within the IPP) and WCASA (WI Coalition Against Sexual Assault) partner with DOJ's Office of Crime Victim Services and OJA on service provision and primary prevention of sexual violence. //2009//

Relationship with SSA, Voc Rehab, Disability Determination, and Transitions

The Disability Determination Bureau (DDB) within DHFS has the SSA contract to determine eligibility of all SSI applicants including those under age 16. Monthly the DDB sends names of new child applicants under review to the CYSHCN Program. The Program sends these families information about the state's Regional CYSHCN Centers and other resources. Outreach by the Regional CYSHCN Centers includes contact with local SSA and Division of Vocational Rehabilitation (DVR) offices. DVR, SSA, and the Regional CYSHCN Centers are youth-to-adult transition stakeholders participating with the State CYSHCN Program in the Statewide Healthy and Ready to Work Transition Consortium.

/2007/ In 2006 the WI Trauma Brain Injury Advisory Board (BIAB) was upgraded to the WI Brain Injury Advisory Council with appointments made by DHFS Secretary. Two MCH CYSHCN and IPP staff were appointed to the Council. //2007//

/2008/ The Brain Injury Advisory Board reports/advises the DHFS Secretary on statewide brain injury issues. //2008//

/2009/ No significant change. //2009//

Relationship with AODA

See discussion under "Relationship with Mental Health".

DPH's Youth Policy Director serves on the AODA State Incentive Grant Advisory Committee staffed by the DDES's BMHSAS. The goal is to create a state plan addressing substance abuse prevention for youth 12 to17. The committee embraced the AODA objectives within the Healthiest WI 2010 State Health Plan.

/2007/ DDES/BMHSAS in consultation with DPH will work to re-establish the AODA Prevention Committee under the auspices of the State Council on Alcohol and Other Drug Abuse focusing on underage drinking. Additional work is occurring on a statewide AODA needs assessment on conditions, magnitude and severity of the substance abuse problems to prioritize the Substance Abuse Block Grant funds.

DPH participated in a joint divisional discussion on the National Underage Drinking Initiative Town Hall meeting in 2006, on evidenced-based strategies to reduce underage drinking. With support from the SAMHSA funded Epidemiologic Workgroup, an analysis and surveillance of the alcohol data will be conducted creating a successful underage drinking compliance checks program if a federal grant is awarded. //2007//

/2008/ DMHSAS received a Substance Abuse and Mental Health Services Administration (SAMHSA) grant - Project Fresh Light, to assess AODA services provided to youth. The Youth Policy Director, CYSHCN staff, and IPP staff collaborate with this program. Project Fresh Light attempts to identify fiscal, regulatory, and policy barriers that impede the provision of accessible evidence-based treatment across a full continuum of care; devise and implement strategies with other State agencies that may fund and/or regulate these services; and improve access to treatment capacity available in communities. The Youth Policy Director was appointed to the DMHSAS State Prevention/Substance-Abuse Prevention Framework-State Incentive Grant Advisory Committee. //2008//

/2009/ The Bureau of Substance Abuse Services has joined the initiative for the "The Integration of Physical Health, Mental Health, Substance Use and Addiction". (See IIIB MCH Advisory Committee) DMHSAS implements the second year of a $2.1 million State Prevention Framework-State Incentive Grant. DPH received $65,000 for an epidemiological alcohol and drug abuse impact study to augment the grant. The focus includes risky drinking behavior (binge or underage) among 12-25 year olds and alcohol related motor vehicle fatalities, injuries, and crashes for individuals ages 16 to 34. //2009//

Relationship with Federally Qualified Health Centers

Implementation of the Medicaid Family Planning Waiver has been an opportunity for the Title V to work in collaboration with FHQCs to promote access to contraceptive and primary care services.

/2007/ No significant change. //2007//

/2008/ Renewal application expands opportunities for collaboration. //2008//

/2009/ Representatives from 2 Milwaukee FQHCs, Milwaukee Health Services, Inc. and Sixteenth St. CHC participated in the HRSA-organized Healthy Birth Outcomes review.

//2009//

Relationship with Primary Care Associations

There is little involvement with primary care associations as Title V focus is infrastructure development and system building. The CYSHCN Program's medical home initiative and the Reproductive Health Program works closely with select of primary care providers.

/2007/ The WI Primary Health Care Association (WPHCA) assists community health centers (CHCs) to expand oral health service capacity, and works with the Title V-funded Dental Hygienist, Chief Medical, and Chief Dental Officers; all 3 were speakers at their annual oral health conference. The CYSHCN Program, in collaboration with its Regional Centers, established Medical Home activities at 2 CHCs (Marshfield Clinic - Chippewa Falls and Sixteenth Street CHC). The administrator of the CHC for Marshfield Clinics presented a quality model of Medical and Dental Home at the 2006 Medical Home Summit. //2007//

/2008/ Oral Health Program staff provide technical support to the WPHCA for grant applications to increase infrastructure and service capacity for oral health at community health centers. Regular bi-monthly meetings occur between staff of the Oral Health Program, the WPHCA, and the WI Office of Rural Health. The purpose is to promote activities that improve access to oral health care for the underserved. //2008//

/2009/ WPHCA is connected to a successful oral health efficiency program in Milwaukee. Medical Home implementation strategies used by CHCs were highlighted at a 2007 Summit. //2009//

Relationship with Tertiary Care Facilities

The Congenital Disorders Program (newborn screening) has contracted with major pediatric centers (i.e., Children's Hospital of WI (CHW), UW Hospital and Clinics including Waisman Center, LaCrosse Gundersen, Marshfield Clinic) to provide diagnostic and treatment services for identified infants. Contracts with genetics providers at tertiary facilities provide genetics services, outreach and implement birth defects reporting to the new WI Birth Defects Registry (WBDR). The CYSHCN Program, as part of the funded WI Integrated System for Communities Initiative (WISC-I), work with the UW-Pediatric Pulmonary Center and CHW to establish mechanisms to transition youth with special health care needs to adult tertiary care.

The number of neonatal intensive care units in WI has increased from 6 in the 1970s to 19 in 2004.

/2007/ Both the UW-PPC and CHW identified quality improvement teams from their specialty clinics as part of the WISCI learning collaborative. Marshfield Clinic now receives MCH funding to support genetic services in northern and western WI.

The number of NICUs has increased to 21. WAPC held an invitational meeting on regionalized perinatal care in October 2005 to determine how WI could transition from two levels of perinatal care (community hospital and perinatal center) to the six levels of care supported by the AAP. //2007//

/2008/ WAPC leads efforts to transition from 2 levels of perinatal care to 6. Criteria sets for the 6 levels of care will be finalized and sent to birth hospitals to conduct self assessments and determine levels of care. A process and external review group will be established to use criteria and deal with discrepancies in self-assessment and levels of care results. FAQs will be developed for the WAPC website, www.perinatalweb.org, to help consumers interpret levels of perinatal care. An established and active WAPC program committee deals with tertiary care issues. //2008//

/2009/ WAPC has established criteria for 6 levels of perinatal care associated with the AAP levels of neonatal care. Criteria worksheets and self assessment materials are found at www.perinatalweb.org. WAPC offered distance-based education on the self-assessment initiative. The WAPC Tertiary Care Committee reviews completed self-assessments. //2009//

Relationship with Public Health, Health Professional Educational Programs, and Universities

Title V coordinates with the UW Schools of Medicine and Nursing, Population Health, and Waisman Center and has worked together on activities: Needs Assessment, Pediatric Pulmonary Center, WI Sound Beginnings, and Medical Home Learning Collaborative. Student internship are available in the Title V Programs. UW DoIT partners in the development of PHIN. The UW Extension system is a partner in training and education. Relationships exist with the State Laboratory of Hygiene, Medical College of WI, Marquette School of Dentistry, the Schools of Nursing at the UW-Milwaukee and Marquette, and the UWM School of Communication, on Medical Home, oral health, perinatal care, birth defects surveillance and prevention, and early hearing detection and intervention.

/2007/ Title V staff are involved with the recently established UW School of Medicine and Public Health as mentors and students. //2007//

/2008/ No significant change. //2008//

/2009/ The oral health program partners with the Marquette Dental School and 2 technical colleges to improve dental access and provide provider training. The MCHB-funded CSHCN Oral Health grant provides training specific to meet the needs of children with special needs. A strong working relationship with our new school of public health was established. A fellow, several MPH students, pediatric residents and undergrad students have worked with DPH. //200

F. Health Systems Capacity Indicators

Introduction

2006 data are required by the TVIS for the Health System Capacity Indicators (HSCIs), forms 17, 18, and 19, for the 2008 Title V MCH Block Grant Application; however, 2006 data are only available for #08. Therefore, from administrative data bases, we used the most recent available data (2005) for #01, 04, and 05A-D; SFY 2006 data are used for #02, 03, 06A-B, 07A-B.

#05A-D are of particular significance since the Wisconsin Department of Health and Family Services' Healthy Birth Outcomes: Eliminating Racial and Ethnic Disparities initiative, is one of the department's priorities.

#09A-B reflect our program capacity to analyze and access state databases relevant to maternal and child health program issues. We use the HSCIs to supplement our program needs and assess our data capacity in relationship to our maternal and child health issues. The HSCIs complement the data indicators in Wisconsin's State Health Plan, Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public, and KidsFirst: The Governor's Plan to Invest in Wisconsin's Future, 2004.

Indicator #09A-B indicates that WI's Title V Program has excellent data from several sources. The SSDI grant is addressing the coordination of data linkages across registries and surveys. Wisconsin was awarded PRAMS in 2006.

/2009/ 2007 data are required by the TVIS for the HSCI forms 17, 18, and 19, for the 2009 Title V MCH Block Grant Application; however, 2007 data are only available for #08.

Therefore, from administrative data bases, we used the most recent available data (2006) for #01, 04, and 05A-D; SFY 2007 data are used for #02, 03, 06A-B, 07A-B. //2009//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	29.5	26.9	27.0	27.0	24.5
Numerator	1002	914	926	926	862
Denominator	339661	339661	342755	342755	352107
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data issue: 2006 data will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Source: Numerator: Wisconsin Department of Health and Family Services, Wisconsin Hospital Discharge Data, Bureau of Health Information and Policy, 2007.
Denominator: Wisconsin Dept. of Health and Family Services, Divsion of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH) data query system, http:// dhfs.wisconsin.gov/wish/,Population Module, accessed 5/17/07.

Notes - 2005
Source: Numerator: Wisconsin Department of Health and Family Services, Wisconsin Hospital Discharge Data, Bureau of Health Information and Policy, 2007.
Denominator: Wisconsin Dept. of Health and Family Services, Divsion of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH) data query system, http:// dhfs.wisconsin.gov/wish/,Population Module, accessed 5/17/07.

Narrative:
Wisconsin's Health Systems Capacity Indicators (Forms 17, 18, 19) present data demonstrating Wisconsin's ability to understand women's and children's health issues in the context of the Title V MCH/CSHCN Program Block Grant. The population served by Title V MCH/CSHCN Program in Wisconsin is small. Nonetheless, we use these data to strengthen existing programs, examine policy issues, encourage policy development, and program implementation to help women, children, and families. These data also bridge Title V MCH/CSHCN Program services to other public health programs in the DPH and agencies that work with families. Below is a brief summary of each indicator.

Our methodology for this indicator changed in 2000; the rate (per 10,000 less than 5 years of age) of children hospitalized for asthma was 25.7 per 10,000 for 2002-2004, using the most recent data available. 2005 data are provisional.

/2008/ In 2001, Children's Health Alliance of Wisconsin (CHAW), with funds from the MCH Program established the Wisconsin Asthma Coalition (WAC). The WAC mission is to develop and implement a sustainable statewide action plan that expands and improves the quality of asthma education, prevention, management, and services and eliminates the disproportionate

burden of asthma in racial/ethnic and low-income populations. Since its inception, the coalition has grown to over 200 members and in 2004, the Wisconsin Asthma Plan was created and implemented. The WAC supports local asthma coalitions throughout Wisconsin. These local coalitions endorse WAC's vision and mission and have adopted the Wisconsin Asthma Plan. Currently there are 9 local asthma coalitions across the state. The Wisconsin Academy of Pediatrics Foundation partners with the CHAW and the Medical College of Wisconsin to coordinate and manage the Allergist Outreach Asthma Education Program for Primary Care Practices. This program promotes early and accurate diagnosis of asthma, and use of evidence-based strategies and guidelines within the practice of clinicians and nurses. In Wisconsin, 8% of children have been diagnosed with asthma. Children age 11-17 years have the highest prevalence of asthma, while children age 0-4 years have the highest emergency department visit and in-patient hospitalization rates. Children age 0-4 years have the lowest prevalence of asthma (5-6%) which may be due to the difficulty in establishing an asthma diagnosis in very young children. //2008//

/2009/ Revision of the Wisconsin Asthma Plan was initiated at a statewide meeting of the Wisconsin Asthma Coalition in March 2008 based upon the Burden of Asthma in Wisconsin-2007 report. The revised plan is expected to be completed by spring 2009 and will address, among other things unique to the state, services needed for persons of racial and ethnic minority groups. Biannual Wisconsin Asthma Coalition meetings continue to provide opportunities to hear from local, state, and national experts and to network. The rate of asthma hospitalizations for children declined in 2007. //2009//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	95.4	97.1	97.5	97.7	96.4
Numerator	27030	29661	30357	31833	32934
Denominator	28332	30539	31149	32585	34154
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2007.

Notes - 2006
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2006.

Notes - 2005
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2005.

Narrative:

Overall, a large proportion of Wisconsin's Medicaid and SCHIP (BadgerCare) enrollees received services; 97.5% and 95.2% respectively during SFY05. BadgerCare began in July 1999 as a Medicaid program to implement SCHIP. Low-income uninsured families who are not eligible for Medicaid qualify for BadgerCare if family income is at or below 185% of the federal poverty level (FPL). Families remain eligible for BadgerCare until their income exceeds 200% FPL. BadgerCare has increased enrollment of children in Medicaid. Many BadgerCare families are mixed with younger children in Medicaid, who are eligible for Healthy Start with incomes up to 185% of the FPL, and older siblings and parents in BadgerCare. An increase in the percentage of infants to age one receiving at least one EPSDT service from BadgerCare is due to continued program expansion.

/2008/ A large proportion of Wisconsin's Medicaid enrollees under age one year continue to receive services; 97.7% during SFY06. BadgerCare continues to increase enrollment of children in Medicaid. BadgerCare Plus, as proposed in Governor Doyle's 07-09 budget, will assure insurance coverage for all children in Wisconsin. //2008//

/2009/ Although declining slightly to 96.4% in 2007, overall a great percentage of Medicaid enrollees under the age of one year are reported as receiving at least one initial periodic health screen. This number should continue to increase as families' access coverage under the expanded Medicaid program, BadgerCare Plus. BadgerCare Plus was passed as a part of Governor Doyle's 07-09 biennial budget and is a new program for children under 19 year of age and their families in Wisconsin who need and want health insurance regardless of income. The program began enrolling participants in February 2008. All children under 19 years old --at all income levels-- can enroll in BadgerCare Plus if they don't have access to health insurance. It offers access to comprehensive, affordable health care for working families and pregnant women in Wisconsin. It is not designed to replace private insurances so specific rules are in place that do not allow most people to drop their private insurance to participate. Families with kids at higher income levels will pay premiums and co-payments for certain services. The plan has two benefit plans--the Standard Plan which covers usual Medicaid services, and the Benchmark Plan which covers usual health care services but fewer optional Medicaid services. The plan received depends on a participant's income. BadgerCare Plus also covers the following groups of persons:

• Pregnant women (up to 300% of the Federal Poverty Level (FPL), which is $51,510 for a family of three);

• Parents and caretakers at higher income levels (up to 200% of the FPL, which is $34,340 for a family of three);

• Young adults who are leaving foster care when they turn 18 (regardless of income);

• Parents with incomes up to 200% FPL who have kids in foster care; and,

• More farm families and self-employed families.

For more information see the following web site:
http://dhs.wisconsin.gov/badgercareplus/index.htm. //2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	91.2	93.8	95.2	94.5	95.4
Numerator	1178	1227	1393	1145	1457
Denominator	1291	1308	1464	1212	1528
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2007.

Notes - 2006
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2006.

Notes - 2005
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2005.

Narrative:
Overall, a large proportion of Wisconsin's Medicaid and SCHIP (BadgerCare) enrollees received services; 97.5% and 95.2% respectively during SFY05. BadgerCare began in July 1999 as a Medicaid program to implement SCHIP. Low-income uninsured families who are not eligible for Medicaid qualify for BadgerCare if family income is at or below 185% of the federal poverty level (FPL). Families remain eligible for BadgerCare until their income exceeds 200% FPL. BadgerCare has increased enrollment of children in Medicaid. Many BadgerCare families are mixed with younger children in Medicaid, who are eligible for Healthy Start with incomes up to 185% of the FPL, and older siblings and parents in BadgerCare. An increase in the percentage of infants to age one receiving at least one EPSDT service from BadgerCare is due to continued program expansion.

/2008/ A large proportion of Wisconsin's SCHIP (BadgerCare) enrollees under age one continue to receive services; 94.5% during SFY06. This declined slightly from 95.2% in SFY05 due to unintended consequences of implementing Medicaid program documentation requirements. BadgerCare began in July 1999 as a Medicaid program to implement SCHIP. //2008//

/2009/ A large proportion of Wisconsin's SCHIP enrollees under age one continue to receive one periodic screen; 94.5% during SFY07. This remained essentially unchanged from SFY06. The percent of SCHIP enrollees receiving services should increase as families' access coverage under the expanded Medicaid program, BadgerCare Plus. BadgerCare Plus was passed as a part of Governor Doyle's 07-09 biennial budget and is a new program for children under 19 year of age and their families in Wisconsin who need and want health insurance regardless of income. The program began enrolling participants in February 2008. All children under 19 years old --at all income levels-- can enroll in BadgerCare Plus if they don't have access to health insurance. It offers access to comprehensive, affordable health care for working families and pregnant women in Wisconsin. For more information see the following web site: http://dhs.wisconsin.gov/badgercareplus/index.htm. //2009//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	85.2	85.2	85.2	84.1	84.1

Numerator	59666	57732	60407	60831	60831
Denominator	69999	67779	70934	72302	72302
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Wisconsin Divsion of Pulbic Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhfs.wisconsin.gov/wish, Prenatal Care Module, accessed 04/29/08.

Notes - 2005
Source: Wisconsin Department of Health and Family Services, Wisconsin Divsion of Pulbic Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhfs.wisconsin.gov/wish, Birth Counts Module, accessed 04/16/07.

Narrative:
2005 data are provisional. In 2004 (final data), 85.2% of Wisconsin women's observed to expected prenatal visits were greater than or equal to 80% on the Kotelchuck index. In 2003, 85% of Wisconsin mothers who gave live birth received first trimester prenatal care. (Note: the methods for calculating the Kotelchuck Index changed in 2003; therefore, we see an increase in the Kotelchuck Index from 2002 to 2003 overall).

/2008/ Programs supporting the maintenance and improvement of quality perinatal services include the Medicaid Prenatal Care Coordination benefit and MCH-funded perinatal care coordination services. These programs strive to identify women early in their pregnancies and assure they receive early and continuous medical prenatal care. Two statewide projects also help to maintain and improve perinatal services. The Wisconsin Association for Perinatal Care is the statewide project to improve maternal health and maternal care. The Infant Death Center of Wisconsin is funded to improve infant health and reduce disparities in infant mortality.

Although this indicator for Wisconsin's total population (85.2%) and white mothers (88.3%) is quite good, this indicator reflects the disparities in perinatal care and birth outcomes that exist for Wisconsin's racial and ethnic populations at 66.6% for Hmong, 74.5% for Hispanic, 75.1% for African American, and 75.3% for American Indian mothers. The Wisconsin Department of Health and Family Services' Healthy Birth Outcomes: Eliminating Racial and Ethnic Disparities initiative, described previously, is one of the department's priorities. Obtaining early and continuous quality prenatal care for populations with disparate outcomes will be one of the messages this initiative will emphasize. We will be able to use this measure, along with others, to track the progress we are making. //2008//

/2009/ This indicator for Wisconsin's total population is 84% with white mothers at 87%. The evidence of racial and ethnic disparities is reflected in 74% of Black/African American women with expected prenatal visits greater than or equal to 80% on the Kotelchuck Index; 59% for Hmong/Laotian; 72% for Hispanic/Latino; and 72% for American Indian

populations.

The addition of BadgerCare Plus has increased the enrollment options for pregnant women into the Medicaid Prenatal Care Coordination benefit as well as prenatal medical care. Efforts to support adequate prenatal care continue through MCH-funded perinatal care coordination services, statewide services provided by the Infant Death Center of Wisconsin and the Wisconsin Association for Perinatal Care (WAPC), and the Healthy Birth Outcomes: Eliminating Racial and Ethnic Disparities initiative. //2009//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	93.4	83.6	93.6	93.9	94.3
Numerator	354265	346556	416581	430158	435887
Denominator	379420	414652	445102	458207	462296
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2007.

Notes - 2006
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2006.

Notes - 2005
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2005.

Narrative:
Generally, a large percentage of Medicaid-eligible children receive services from the Medicaid Program in Wisconsin. 93.6% of Medicaid-eligible children received a service paid by the Medicaid Program in SFY05, an increase from 83.6% in SFY04. We do not know the reason for the decrease in SFY04; it may be from methodological issues or a random fluctuation. We will watch this indicator closely for the next few years.

/2008/ A large percentage of Medicaid-eligible children receive services from the Medicaid Program in Wisconsin. 93.88% of Medicaid-eligible children received a service paid by the Medicaid Program in SFY06, a slight increase from 93.6% in SFY05. An effort to expand the BadgerCare Program in Wisconsin to cover all uninsured children is included in Governor Doyle's 07-09 budget request. //2008//

/2009/ A large percentage of Medicaid-eligible children receive services that are paid for by the Medicaid Program in Wisconsin; the percent increased to 94.3% during SFY 2007. This is a slight increase from 93.9% in SFY 2006 and should continue to increase with the new

benefit, the BadgerCare Plus program that was passed in Governor Doyle's 07-09 state budget and began enrolling participants on February 1, 2008. This is a new program for children under 19 year of age and their families in Wisconsin who need and want health insurance regardless of income. All children under 19 years old --at all income levels-- can enroll in BadgerCare Plus if they don't have access to health insurance. It offers access to comprehensive, affordable health care for working families and pregnant women in Wisconsin. For more information see the following web site: http://dhs.wisconsin.gov/badgercareplus/index.htm. //2009//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	53.1	34.0	32.6	32.4	17.9
Numerator	42289	28647	28599	29611	16764
Denominator	79672	84143	87771	91507	93426
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2007.

Notes - 2006
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2006.

Notes - 2005
Source: Numerator and denominator from the Medicaid Evaluation and Decision Support Data Warehouse for SFY2005.

Narrative:
32.6% of EPSDT eligible children aged 6 through 9 years received any dental services during SFY05, a slight decrease from 34.9% in SFY05, but a significant decrease from 53.1% in SFY03. We do not know the reason for this decrease, although it may be due to an expansion of the program with a larger number of enrollees but fewer children receiving services. We will watch this closely for the next few years as the program continues to expand.

/2008/ The percentage of EPSDT eligible children aged 6 through 9 years of age has remained stable (2004=34%, 2005=32.6%, & 2006=32.3%) over the last few years. As in other states, it remains a challenge to find dental providers willing to accept new Medicaid patients. Low reimbursement rates are the most commonly mentioned reason. In addition, there is a lack of capacity in the community health center/safety net clinic system. The Wisconsin Medicaid program sent out a Request for Information that will ask for proposals to revise the dental Medicaid component. //2008//

/2009/ The percentage of EPSDT eligible children aged 6 through 9 years of age who had

received any dental services during the year had remained relatively stable since 2004. However in 2007 we experienced a rather significant decrease (17.9%). It continues to remain a problem finding dental providers willing to accept Wisconsin Medicaid. Medicaid reimbursement for dental providers contributes to the problem. Although it varies from state to state, the Medicaid reimbursement rate for dental professionals is typically much lower than private pay patients and doesn't cover office overhead costs associated with treatment. Wisconsin is working aggressively to increase capacity, especially in community health centers and safety net clinics. Currently there is a lack of consistent ongoing dental care in those agencies, which presents another barrier to care. There is a declining dental provider population, with more dentists reaching retirement age and a short supply of new dental graduates. This disparity makes it a challenge for patients to obtain appointments, as well as for communities to retain dental providers. The Wisconsin Office of Rural Health has consistently increased their dental recruitment rates from (5) in 2005 to (15) in 2007, with 14 of the 15 providers placed in community health centers. Wisconsin is unique in that Medicaid reimbursement for dental services is through both fee-for-service and HMO models. The HMO's, who serve the largest portion of Wisconsin Medicaid recipients in and around Milwaukee typically have a lower utilization rate than those in fee-for-service. Wisconsin is examining the usefulness of this relationship and is committed to finding an appropriate solution. //2009//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	13446	13727	14201	14590	15289
Denominator	13446	13727	14201	14590	15289
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

The denominator, 15,289 is in a report from the Social Security Administration and the numerator is the same. Data Issue: All SSI beneficiaries less than 16 years old are automatically eligible for Wisconsin's Medicaid Program which provides comprehensive rehabilitative services. This indicator is consistent with other states with universal Medicaid coverage for these services. Titles V's role is focused on assuring families are aware of and enrolled in SSI. As such, under an MOU agreement, the Disability Determination Bureau of SSA electronically provides the CYSHCN program names and addresses of children under age 16 who have applied for SSI benefits. In 2007, 2,416 families were sent information from the CYSHCN program about the regional CYSHCN Centers, Family Voices, Birth to 3 and other disability resources, whether or not they were found eligible for SSI.

Notes - 2006

The denominator, 14,590 is in a report from the Social Security Administration and the numerator is the same. Data Issue: All SSI beneficiaries less than 16 years old are automatically eligible for Wisconsin's Medicaid Program which provides comprehensive rehabilitative services. This indicator is consistent with other states with universal Medicaid coverage for these services.

Titles V's role is focused on assuring families are aware of and enrolled in SSI. As such, under an MOU agreement, the Disability Determination Bureau of SSA electronically provides the CYSHCN program names and addresses of children under age 16 who have applied for SSI benefits. In 2006, 2,685 families were sent information from the CYSHCN program about the regional CYSHCN Centers, Family Voices, Birth to 3 and other disability resources, whether or not they were found eligible for SSI.

Notes - 2005
The denominator, 14,201 is in a report from the Social Security Administration and the numerator is the same. Data Issue: All SSI beneficiaries less than 16 years old are automatically eligible for Wisconsin's Medicaid Program which provides comprehensive rehabilitative services. This indicator is consistent with other states with universal Medicaid coverage for these services. Each month, SSA sends the Wisconsin CYSCHN Program the names and addresses of all children under 16 years with filed applications for SSI benefits. Families are then sent information about the regional CYSHCN Centers and other resrouces.

Narrative:
All SSI beneficiaries less than 16 years old are automatically eligible for Wisconsin's Medicaid program which provides comprehensive rehabilitative services. The CSHCN Program, through an MOU with SSA, receives the names and addresses of all children less than 16 years old making application to SSI, and on a monthly basis, sends information about the Regional CSHCN Centers and other resources to these families.

/2008/ No significant change. //2008//

/2009/ As of December 2007, 15,289 children under the age of 16 received SSI payments, and as mentioned above are automatically eligible for Wisconsin Medicaid program. The CYSHN program provided information and resource information to 2,416 families who have made application to SSI. Direct services were provided through the CYSHCN Regional Centers to 247 clients less than 16 years of age on SSI. //2009//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2006	matching data files	9	5.1	6.8

Notes - 2009
In 2006 in Wisconsin, there were 69,951 occurrent and resident births; 44.1% (30,867/69,951) were to women whose birth was paid by Medicaid.
Source: Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services.

An attachment is included in this section.

Narrative:
Women who did not have Medicaid as a source of payment for the birth had better perinatal outcomes than women who were on Medicaid (05A-o5D). In 2004, the percentage of low birth weight babies was almost twice for women who were on Medicaid compared to non-Medicaid

women (8.0% to 4.1%).

/2008/ The attached table presents data for Indicator #05A by race and ethnicity, using births that occurred in Wisconsin to Wisconsin residents in 2005.

See Attachment to Section III. F. - HSCI (Table 5A)

On average, Wisconsin's perinatal data are driven by the good outcomes of the white, majority population. This table shows that among mothers who are Medicaid-eligible, some racial and ethnic groups compare favorably to the majority white population. However, it holds true for low birth weight, that the greatest disparities exist for African American mothers, both Medicaid-eligible and non-Medicaid. (For all the Health System Capacity tables showing race and ethnicity, numbers for Hawaiian and Pacific Islander and Unknown are very small, with extreme percents, and therefore should be ignored.)

Programs supporting the maintenance and improvement of perinatal outcomes include the Medicaid Prenatal Care Coordination benefit and MCH-funded perinatal care coordination services. These programs provide psychosocial support to enhance the medical prenatal and postpartum care. Services include outreach, assessment of strengths and needs, care coordination, health education and nutrition counseling. Two statewide projects also help to maintain and improve birth outcomes. The Wisconsin Association for Perinatal Care is the statewide project to improve maternal health and maternal care. The Infant Death Center of Wisconsin is funded to improve infant health and reduce disparities in infant mortality. These projects are providing education to health care providers and consumers, promoting preconception care as a key strategy to improve birth outcomes, supporting pilot projects in communities with high rates of disparities in birth outcomes, and supporting coalition-building activities.

As mentioned in HSCI #4, the Wisconsin Department of Health and Family Services' Healthy Birth Outcomes: Eliminating Racial and Ethnic Disparities initiative, is one of the department's priorities. Low birthweight rates among all women, both Medicaid and non-Medicaid will be tracked as part of this initiative. //2008//

/2009/ The overall percent of low birth weight births in 2006 was 6.9%, primarily due to the white majority with (6.2%). The disparities continue with the African American population (13.5%); Hispanic/Latino (6.2%); American Indian (6.8%); Laotian/Hmong (6.1%). The Medicaid Prenatal Care Coordination benefit and MCH-funded perinatal care coordination services continue to provide psychosocial support to enhance medical prenatal and postpartum care. A Doctoral research project looking at the birth outcomes of infants born to mothers who received Prenatal Care Coordination services demonstrated PNCC significantly protected against low birth weight, very low birth weight, preterm birth and NICU admission (16-29% less likely to happen). The Infant Death Center of Wisconsin and the Wisconsin Association for Perinatal Care continue to promote preconception health and health care as a key strategy to improve birth outcomes. BadgerCare Plus was implemented in 2008 to increase the number of women who have access to these programs. Title V staff are participating on a Medicaid Pay-for-Performance Workgroup to provide recommendations for improving birth outcomes among Medicaid women. //2009//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

MCH populations in the State					
Infant deaths per 1,000 live births	2006	matching data files	8.6	4.8	6.5

Notes - 2009
In 2006 in Wisconsin, there were 69,951 occurrent and resident births; 44.1% (30,867/69,951) were to women whose birth was paid by Medicaid.
Source: Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services.

An attachment is included in this section.

Narrative:
Wisconsin infant birth and death data are maintained by DHFS, DPH, BHIP, Vital Statistics unit and 2003 and 2004 data for infant deaths (matching data files) and the Kotelchuck Index) were not linked as of 7/05/06 by the Bureau of Health Information and Policy. In 2002, the infant mortality rate for births paid for by Medicaid was higher than for births not paid by Medicaid (7.7% to 5.9%); the overall rate was 6.6.

/2008/ The attached table presents data for Indicator #05B by race and ethnicity, using births that occurred in Wisconsin to Wisconsin residents in 2005.

See Attachment to Section III. F. - Table 5B

Again, according to these data, the greatest disparity is between the white rate and African American rate. For this reason, we are focusing our initial efforts to eliminate racial and ethnic disparities in birth outcomes, with the African American communities in our state. The Hispanic infant mortality rate, 9.5, for "Other" (insured, self-payer, or unknown) was calculated from 12 deaths/1,262 births; for Medicaid, there were 28 deaths and 4,925 births or 5.7 deaths/1,000. See also, HSCI 05A. //2008//

/2009/ The total outcomes in Wisconsin reflect a low mortality due to the white population data with 4.9 infant deaths per 1,000 live births. The disparities are reflected in the outcomes by race and ethnicity with 17.2 Black infant deaths per 1,000 live births and 6.3 Hispanic infant deaths per 1,000 live births. As stated earlier, the Medicaid Prenatal Care Coordination program along with the MCH-funded perinatal care coordination program are providing direct, strength based services to pregnant women to help to reduce these disparities. The regional Healthy Babies Action teams are focused on identifying population based strategies to reduce disparities in outcomes. In addition, Title V staff are participating on a Medicaid Pay-for-Performance Workgroup to provide recommendations for improving birth outcomes among Medicaid women. //2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving	2006	matching data files	75.4	90.2	83.7

prenatal care beginning in the first trimester					

Notes - 2009
The value for "All" does not equal the value for National Performance Measure 18 because the data sources were different. This value was calculated using a denominator of 69,951 for Wisconsin occurrent and residents births; of these 30,867/69,951 = 44.1% were to women whose birth was paid by Medicaid. The denominator used for National Performance Measure #18 was 72,302 for occurrent births in Wisconsin.
Source: Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services.

An attachment is included in this section.

Narrative:
2004 data for prenatal care utilization also show that women on Medicaid had lower percentages compared to women not on Medicaid (74.6% to 92.9% respectively) first trimester prenatal care and 85% overall.

/2008/ The attached table presents data for Indicator #05C by race and ethnicity, using births that occurred in Wisconsin to Wisconsin residents in 2005.

See Attachment to Section III. F. - Table 5C

For this indicator, the differences between Medicaid-eligible and non-Medicaid for all racial and ethnic groups is striking (showing much better rates for women not on Medicaid). These data also show that for entry into first trimester care for women on Medicaid, efforts are especially needed to reach Hispanic and Asian women. The new BadgerCare prenatal benefit provides Medicaid coverage to undocumented and incarcerated women and should make a change in this indicator. See also HSCI 04. //2008//

/2009/ While the percentage of women receiving first trimester prenatal care is good for the state overall (84%) and white women (87%), disparities exist for Black (74%), Hmong (59%), American Indian (72%) and Hispanic (72%) women.

The addition of BadgerCare Plus has increased the enrollment options for pregnant women into prenatal medical care as well as the Medicaid Prenatal Care Coordination benefit. PNCC and MCH-funded perinatal care coordination services strive to identify women as early as possible in their pregnancies and support early and continuous prenatal care. Title V staff are participating on a Medicaid Pay-for-Performance Workgroup to provide recommendations for improving birth outcomes among Medicaid women. The Medicaid Program is developing on-line express enrollment for pregnant women and newborns. //2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant	2006	matching data files	77.1	89.5	84

women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])					

Notes - 2009

The value for "All" does not equal the value for National Performance Measure 18 because the data sources were different. This value was calculated using a denominator of 69,951 for Wisconsin occurrent and residents births; of these 30,867/69,951 = 44.1% of births, occurrent and residents, were to women whose birth was paid by Medicaid.

The denominator used for National Performance Measure #18 was 72,302 for occurrent births in Wisconsin.

Source: Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services.

The value for "All" does not equal the value for HSCI 04 because the data sources were different. This value was calculated using a denominator of 69,951 for women in Wisconsin who were residents in Wisconsin and on Medicaid; the denominator for HSCI 04 was 72,302 for occurrent and resident births in Wisconsin.

An attachment is included in this section.

Narrative:

Wisconsin infant birth and death data are maintained by DHFS, DPH, BHIP, Vital Statistics unit and 2003 and 2004 data for infant deaths (matching data files) and the Kotelchuck Index) were not linked as of 7/05/06 by the Bureau of Health Information and Policy. In 2002, 69.5% of women on Medicaid received adequate prenatal care compared to 84.4% of women were not on Medicaid and 78.4% overall. (Note: the methods for calculating the Kotelchuck Index changed in 2003 [although data for the Medicaid and non-Medicaid populations were not linked as of 7/05]. Therefore, we see an increase in the Kotelchuck Index from 2002 to 2003 overall).

/2008/ The attached table presents data for Indicator #05D by race and ethnicity, using births that occurred in Wisconsin to Wisconsin residents in 2005.

See Attachment to Section III. F. - Table 5D

These data present a consistent pattern in Wisconsin, that for all racial and ethnic groups, Medicaid women do not fair as well as their non-Medicaid counterparts regarding adequacy of care. Similarly, disparities exist between whites and all other racial and ethnic groups, for both Medicaid and non-Medicaid women. The Medicaid Program has joined in partnership with DPH in the efforts we are pursuing for the disparities in birth outcomes initiative. See the 2006 Progress Report on the Framework for Action at www.dhfs.wisconsin.gov/healthybirths/. It will be helpful to review these data with Medicaid staff and to track these as we continue to work together. See also, HSCI 04. //2008//

/2009/ BadgerCare Plus was implemented in 2008 to increase the number of pregnant women receiving early access to healthcare. The program provides for the uninsured as well as the underinsured populations in the State of Wisconsin. Title V staff are participating on a Medicaid Pay-for-Performance Workgroup to provide recommendations for improving birth outcomes among Medicaid women. //2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2007	200

Narrative:
The percent of poverty level for eligibility for infants, children 1 to 18, and pregnant women for Medicaid and BadgerCare is 185%; families may remain in BadgerCare up to 200% FPL.

/2008/ Governor Jim Doyle has proposed BadgerCare Plus, which would combine the current Family Medicaid, BadgerCare (SCHIP), and Healthy Start eligible populations and programs. The following new populations are proposed, with implementation beginning no sooner than January 2008.

1. All children (birth to age 19) with incomes above 185% of the federal poverty level (FPL)
2. Pregnant women with incomes between 185 and 300% of the FPL
3. Parents and caretaker relatives with incomes between 185 and 200% of the FPL
4. Caretaker relatives with incomes between 44 and 200% of the FPL
5. Parents with children in foster care with incomes up to 200% of the FPL
6. Youth (ages 18 through 20) aging out of foster care
7. Farmers and other self-employed parents with incomes up to 200% of the FPL, contingent on depreciation calculations

In addition, Wisconsin will streamline eligibility; assist employees in purchasing quality, employer-sponsored coverage; and provide incentives for healthy behaviors. This proposal represents the most sweeping reform of the low-income, family portion of the Medicaid program in Wisconsin since its inception in 1967. The state is also seeking federal approval for the changes. BadgerCare Plus is targeted for implementation January 1, 2008. //2008//

/2009/ BadgerCare Plus is implemented, February 2009, with the new categories outlined above. Federal approval is being sought to cover childless adults. The Medicaid Program is developing on-line express enrollment for pregnant women and newborns. //2009//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2007	185
INDICATOR #06	**YEAR**	**PERCENT OF**

The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.		**POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2007	200

Narrative:
The percent of poverty level for eligibility for infants, children 1 to 18, and pregnant women for Medicaid and BadgerCare is 185%; families may remain in BadgerCare up to 200% FPL.

/2008/ See narrative for 06A. //2008//

/2009/ See narrative for 06A. //2009//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2007	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2007	200

Narrative:
The percent of poverty level for eligibility for infants, children 1 to 18, and pregnant women for Medicaid and BadgerCare is 185%; families may remain in BadgerCare up to 200% FPL.

/2008/ See narrative for 06A. //2008//

/2009/ See narrative for 06A. //2009//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes

Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	2	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

The SSDI Director is facilitating meetings to discuss linking of both newborn screening and newborn hearing screening files with birth records in SPHERE. Staff have obtained test files, written match criteria, and conducted a pilot of linking files from the SPHERE Birth Record and newborn hearing screening files from WE TRAC with a 99% success rate. The new system for receiving and processing birth records will become operational in 2009 and allow for newborn screening files to also be linked to the newborn hearing screening and birth records.

Wisconsin was awarded PRAMS in April 2006; our first survey to mothers who had a live birth in 2007 was mailed in mid-May 2007. We do not expect to have data for analysis until late 2008 or early 2009. Wisconsin PRAMS is a collaborative project between the Bureaus of Health Information and Policy and Community Health Promotion (which administers Title V), Division of Public Health.

Narrative:

The Title V MCH/CSHCN Program has timely data from several other sources, including: linked infant birth and death files, linked birth certificates and Medicaid eligibility files, and linked birth records and WIC eligibility files. Birth records and NBS files are not linked; however, the SSDI grant is addressing that issue. SSDI continues to serve as the key mechanism to coordinate data linkages across registries and surveys, and to provide critical information on State data systems capacity. The focus continues to be the ability of Wisconsin to assure MCH Program access to policy and program relevant information. As part of Wisconsin's Birth Defects Prevention and Surveillance System, the Wisconsin Birth Defects Registry (WBDR) was developed in 2003 and was rolled out statewide in 2004. The WBDR allows for real-time reporting of birth defects electronically either as individual reports or by uploading from an electronic records system to the secure website. More than 60 reporters are using the WBDR Website to report. One large facility reports by uploading from their electronic patients records system to the WBDR Website. Two additional large facilities are exploring reporting in the same way. A 2005 calendar year report will be finalized in October 2006. The updated version of the Wisconsin Early Hearing Detection and Intervention Tracking, Referral and Coordination (WE-TRAC) System was released in late 2005 and a phased roll-out with statewide regional trainings were begun. WE-TRAC is linked to the Wisconsin State Lab of Hygiene newborn screening data system and tracks newborns from initial hearing screening through referral. Wisconsin was awarded PRAMS in April 2006.

/2008/ The Title V MCH/CYSHCN Program has timely data from several other sources, including: linked infant birth and death files, linked birth certificates and Medicaid eligibility files, and linked birth records and WIC eligibility files. Wisconsin was awarded PRAMS in April 2006; the first surveys were mailed in May to moms who have had a live birth in early 2007; data for analysis will be available in 2008. Birth records and NBS files are not linked; however, the SSDI grant is addressing that issue. SSDI continues to serve as the key mechanism to coordinate data linkages across registries and surveys, and to provide critical information on State data systems capacity. The focus continues to be the ability of Wisconsin to assure MCH Program access to policy- and program-relevant information. During 2006-2007, Wisconsin is working on a data linkage project to link preliminary birth records from the MCH reporting system, SPHERE, to newborn hearing screening records from the Wisconsin Early Hearing Detection and Intervention Tracking, Referral and Coordination (WE-TRAC) System. In the next phase of the project, the linked records will also be linked with birth defects records from the Wisconsin Birth Defects Registry (WBDR). The purpose of the project is to assure that all Wisconsin newborns are accounted for and that appropriate screening and follow-up services are offered to all newborns and their families. //2008//

/2009/ SSDI continues to serve as the key mechanism to coordinate data linkages across registries and surveys, and to provide critical information on State data systems capacity. The focus continues to be the ability of Wisconsin to assure MCH Program access to policy- and program-relevant information in a timely manner. In February of 2008, a pilot was completed which found 99% of birth records in SPHERE were able to be matched to a WETRAC record. This pilot demonstrated the ability to successfully link these records. In 2009, Vital Records will implement a new system for receiving and processing birth records which will allow the blood card number to be added to the record and will serve as a unique identifier. This addition will open an opportunity for birth records to be matched to both the Newborn Screening results and Newborn Hearing Screening results. //2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Wisconsin Youth Tobacco Survey	2	Yes

Notes - 2009

The Wisconsin Youth Risk Behavior Survey (YRBS) is administered every other year by the Wisconsin Department of Public Instruction in collaboration with the Wisconsin Division of Public Health; the 2007 survey is the most recent one available.

The Wisconsin Youth Tobacco Survey is a comprehensive measure of youth awareness, attitudes, and related behaviors about tobacco in Wisconsin. The survey is conducted in both public middle and high schools during the spring semester of even years (2008, 2010).

Narrative:

The BCHP's Tobacco Prevention Section has responsibility to reduce tobacco use and exposure in every Wisconsin community. The section analyzes the YRBS tobacco questions on a regular basis, and administers the Wisconsin Youth Tobacco Survey every other year. BCHP staff work closely with Wisconsin DPI staff and capacity building for the YRBS; they have regular meetings and are actively involved in the YRBS analysis and dissemination of results.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The following grid depicts the National and State Performance Measures, their objectives and the most recent indicators. We have noted whether or not we have met the objective. The following narrative sections include discussions on Wisconsin's ten state priorities, the national performance activities, state performance measure activities, and other program activities.

See Attachment to Section IV. A. - Background and Overview
(Grids of National and State Performance Measures)
An attachment is included in this section.

B. State Priorities

The Division of Public Health, Bureau of Community Health Promotion, Family Health Section staff identified possible strategies or activities that will help Wisconsin move toward addressing the needs because it is not enough to agree that something is a problem. We must have a reasonable strategy for addressing the problem, in order for it to rise to the level of a priority need or a Wisconsin State Performance Measure. The public health assurance function is carried out in many ways or approaches from: providing services directly, contracting services, developing legislation, educating professionals and consumers, building systems, and/or improving data capacity. During the needs assessment process, staff considered effectiveness, efficiency, and acceptability based on their experience and insight regarding what can work -- within the sphere of control in state government.

1. Effectiveness:
• How effective is this to leading to a solution?
• Is it reachable by known interventions?
• Can it be tracked and measured?
• What are the health consequences of not implementing such a strategy/activity?

2. Efficient:
• How efficient is this to leading to a solution?
• Does the solution produce a result with a minimum of effort, expense, or waste?
• Is this appropriate use of Title V, Block Grant dollars?

3. Acceptable:
• How acceptable is this strategy/activity to clients, providers, and within state government?
• What is the degree of demographic, racial, and ethnic disparity?
• Does this solution help achieve a Healthiest Wisconsin 2010 Health Priority?
• Does this solution help promote the Governor's KidsFirst Initiative?

Wisconsin's 10 Priority Needs

1. Disparities in Birth Outcomes

Disparities in birth outcomes are related to NPM #15, #17, and #18 by addressing very low birthweight and early prenatal care. Wisconsin's continuing SPM #9 addresses the ratio of the Black infant mortality rate to White infant mortality rate.

In 2004, 420 Wisconsin infants died during the first year of life. Of these, 245 were white, and 125 were African American. The white infant mortality rate of 4.5 deaths per 1,000 live births in Wisconsin met the national Healthy People 2010 objective for the first time in 2004. In contrast, infant mortality rates for Wisconsin racial/ethnic minority populations have not met this objective; the African American infant mortality rate was 19.2. The disparity ratio of African American to

white infant mortality rates was 4.3, meaning an infant born to an African American woman was 4.3 times more likely to die before reaching its first birthday than an infant born to a white woman. If African American infant mortality were reduced to the white infant mortality level, 96 of the 125 deaths would have been prevented.

For each racial/ethnic minority group in Wisconsin, the 2002-2004 infant death rate exceeded that of whites. The infant mortality rate of American Indians was 1.8 times greater than the white rate; the rate for Laotian/Hmong was 1.6 times the white rate. In comparison to all groups, the risk of death during the first year of life was greatest for African Americans.

Relative to other reporting states and the District of Columbia, Wisconsin's infant mortality ranking has fallen since 1979-1981. In 1979-1981, relative to other ranked states, Wisconsin had the third lowest African American infant mortality rate. For the 2001-2003 period, Wisconsin ranked 39th out of reporting states and the District of Colombia, indicating it had the highest African American infant mortality rate. Since 1979-1981, Wisconsin's rank based on white infant mortality rates has also declined relative to other states, moving from a rank of 5 in 1979-1981 to 21 in 2000-2002. Thus, while Wisconsin's white infant mortality rate declined during the past two decades, improvement did not keep pace with many other states.

The infant mortality disparity of Blacks as compared to Whites ranked Milwaukee as the 4th worse among 16 U.S. cities (Big Cities Health Inventory, 2003).

2. Contraceptive Services

This priority takes into account the concerns voiced by many during the needs assessment process regarding unintended pregnancy, teen births, and abstinence from sexual activity. Our priority aligns with NPM #8 which examines rate of teen births. Wisconsin's new SPM #1 attempts to examine the access and utilization of contraceptive services by monitoring the percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.

Women are defined as "in need of contraceptive services and supplies" during a given year if they are ages 13-44 and meet three criteria: 1) they are sexually active, that is, they have ever had intercourse; 2) they are fecund, meaning that neither they nor their partner have been contraceptively sterilized, and they do not believe that they are infecund for any other reason; and 3) during at least part of the year, they are neither intentionally pregnant nor trying to become pregnant.

Women are defined as "in need of publicly-funded contraceptive services and supplies" if they meet the above criteria and have a family income under 250% of the federal poverty level (estimated to be less than $42,625 for a family of four). All women younger than 20 who need contraceptive services and supplies are assumed to need publicly supported care, either because their personal incomes are below 250% of poverty or because of their heightened need--to preserve confidentiality--for obtaining care that not depend on their family's resources or private insurance.

640,420 women ages 13-44 are estimated to be in need of contraceptive services and supplies in Wisconsin. Ninety-three percent of females aged 15-44 years at risk of unintended pregnancy used contraception in 1995. Approximately 27% of the estimated need for public support family planning services has been met through the Medicaid Family Planning Waiver through March 2006.

3. Mental Health for All Population Groups

Mental health as a priority need links with the NPM #16 that focuses on deaths from suicide. Wisconsin's SPM #3 monitors the percent of children, ages 6 months -- 5 years, who have age

appropriate social and emotional developmental levels. (It is important to note that we recognize the importance of women's mental health, postpartum depression, the stigma associated with a mental illness diagnosis and adolescent indicators of need, however our SPM focus is on young children.)

According to the 2003 National Survey of Children's Health, 33 % of parents of young children, aged 0-5 years of age, have at least one concern about their child's learning, development or behavior and over 10% of children aged 3-17 are reported to have moderate or sever difficulties in the areas of emotions, concentration, behavior, or getting along with others. In addition, the 2005 National Health Interview Survey found 20% of boys and 12% of girls aged 4-17 years of age had parents who had talked to a health care provider or school personnel about their child's emotional or behavioral difficulties during the previous 12 months. Mental Health hospitalizations of children have increased from 4.7 per 1,000 children in 1997 to 5.5 per 1,000 children in 2003 according to the 2005 WisKids Count Data Book compiled by the Wisconsin Council on Children and Families, Inc.

4. Medical Home for All Population Groups

This priority need is an outgrowth of the NPM #3 which focuses on children with special health care needs; it also supports Wisconsin's new SPM #5 which maintains the focus on children with special health care needs and includes the priority of a dental home. The American Academy of Pediatrics believes that all children should have a medical home and as part of their focused priorities, the Wisconsin MCH Advisory Committee identified medical and dental home for all children. In addition, Wisconsin has been identified by MCHB as a Medical Home Leadership state.

A child with a medical home does not use a hospital emergency room as their primary place of care. According to the Wisconsin Family Health Survey in 2004, 1% of all children (under age 18) used the hospital emergency room as their primary place of care; among both Hispanic and white children, less than 1% used the emergency room as their usual place for care, while 5% of African American children did so. National SLAITS data indicate that: children without a medical home are twice as likely to experience delayed or forgone care; non-White children are significantly less likely to have a medical home; and poor children and children whose special health care needs have a significant adverse impact on their activity levels are more than twice as likely not to have a medical home and have unmet health care needs.

5. Dental Health (including CSHCN, racial/ethnic, linguistic, geography, income)

The dental health priority has shifted focus to access and accessibility. The NPM #9 concentrates on delivery of protective sealants whereas Wisconsin's new SPM #2 will observe the percent of Wisconsin Medicaid and BadgerCare recipients, ages 3-20, who received any dental services during the year.

Both Governor Jim Doyle, in his KidsFirst Initiative, and the state health plan, Healthiest Wisconsin 2010, identify oral health as a critical need. The National Survey of CSHCN reported that 83.1% of Wisconsin CSHCN required dental services and 92.6% received all needed dental services. 7.4% did not receive all needed dental services, which translates to 13,000 children with unmet oral health needs each year. The Wisconsin Family Health Survey revealed that 4.3% of CSHCN, or 12,800 children, did not receive needed dental care. The two primary reasons given were they couldn't afford dental care or had inadequate insurance.

In Wisconsin, 30.8% of children have at least one primary or permanent tooth with an untreated cavity. Compared to White children, a significantly higher proportion of minority children had caries experience and untreated decay. Twenty-five percent of the White children screened had untreated decay compared to 50% of African American children, and 45% of Asian children, and 64% of American Indian children. In addition, children who attend lower income schools have

significantly more untreated decay (44.5%) compared to children in both middle (31.7%) and higher income schools (16.6%).

6. Health Insurance and Access to Health Care

There is a strong relationship between health insurance coverage and access to health care. During the needs assessment process, our stakeholders had difficulty looking at one need without the other; thus, we combined them into one priority. The NPM #13 requires data on percent of children without health insurance. The Wisconsin SPM #6 monitors the movement to address this need by measuring the percent of children less than 12 years of age who receive one physical exam a year.

Wisconsin ranks high in the proportion of people who have health insurance. However, state data indicate that the maternal and child health population are less likely to be insured for the entire year. This presents opportunities for public health system partners to intervene at the individual, family and community-wide level and corresponds with the state health plan, Healthiest Wisconsin 2010. Within the state health plan, health insurance coverage is specifically delineated as key to whether or not health care services are likely to be sought and obtained.

7. Smoking and Tobacco Use

The Wisconsin continuing SPM #7 looks at percent of women who use tobacco during pregnancy. Smoking during pregnancy is a major risk factor for infant mortality, low birthweight, prematurity, stillbirth, and miscarriage. Overall in 2004, 14% of pregnant women in Wisconsin reported smoking during pregnancy; this rate is higher than the national rate of 10.2% (preliminary data 2004). In terms of racial differences, American Indian women continue to report the highest percentage of smoking during pregnancy, nearly 2.5 times as high as the overall state percentage.

8. Intentional Childhood Injuries

Discussions during the needs assessment process resulted in dividing injury into intentional and unintentional injuries. The NPM #16 relates to the priority as it addresses deaths from suicide among older teens. However, Wisconsin's new SPM #4 focuses on child abuse, neglect and maltreatment issues. We will monitor the number of substantiated reports of child maltreatment to Wisconsin children, ages 0-17, during the year.

In 2004, there were 42,451 total reports of child abuse and neglect with 8,600 substantiations in Wisconsin. This reflects a substantiation rate of 6.1 per 1000 of Wisconsin's children and youth between ages of ages newborn through 17 years. The largest number of substantiated reports (2,254) is for youth between the ages of 15 and 17 with 1,617 reported substantiations of sexual abuse.

9. Unintentional Childhood Injuries

The priority need for unintentional childhood injuries relates with the NPM #10 and the new SPM #10 both addressing death from motor vehicle crashes but for different age groups; 14 and under; and 15-19, respectively.

In Wisconsin, there are almost two times the number of unintentional injuries and deaths than intentional or violent injuries and deaths in the 0-19 age group. From 2000-2004, more than 1,600 children, teenagers, and young adults died from injuries (682 from motor vehicle-related injuries) and more than 31,000 were hospitalized; 51% of hospitalizations were caused by poisonings (19%), falls (16.8%), and motor vehicle-related injuries (16.4).

10. Overweight and At-Risk-for-Overweight

The concern about overweight and at risk for overweight was clear during the needs assessment process and surfaced as a priority need for Wisconsin. The priority need for overweight and at risk of overweight relates to the new NPM #14 and also NPM #11 (breastfeeding). Wisconsin's continuing SPM #8 also looks at the percent of children, 2-4 years who are obese or overweight.

The prevalence of overweight in Wisconsin children from age 2 to age 5 is 13.3%. Overweight and at-risk-for-overweight has increased among all racial and ethnic groups. The prevalence of at-risk-for-overweight for children aged 2 to 5 or older increased from 13.8% in 1994 to 16.3% in 2004. In 2004, the highest rates for overweight and at-risk-for-overweight were among American Indian (20.5% and 22.6%), Hispanic (18.1% and 18.3%) and Asian (15.8% and 17.1%). Rates for Whites were slightly lower at 11.9% and 16.0%, and Blacks were at 10.7% and 14.3%.

/2007/ There were no significant changes in Wisconsin's ten priority needs. Our full 172 page document, including the Data Detail Sheets can be found as an attachment to Section II - Needs Assessment. //2007//

/2008/ These ten priority areas remain priorities as well as our State and National Performance measures. //2008//

/2009/ No significant change. //2009//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	95	124	117	119	106
Denominator	95	124	117	119	106
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2007. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care.
Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2008. The number of screened through NBS and confirmed with a condition.
Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

Notes - 2006

Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2007. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care.
Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2007. The number of screened through NBS and confirmed with a condition.
Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

Notes - 2005
Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2005. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care.
Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2005. The number of screened through NBS and confirmed with a condition.
Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

a. Last Year's Accomplishments
1. Newborn Screening--Population-Based Services--Infants

In 2007, 70,666 infants were screened for 47 different congenital disorders. 106 infants were confirmed with a condition screened for by the NBS Program and 100% were referred for appropriate follow-up care.

2. Diagnostic Services--Direct Health Care Services--Infants

The Department provided necessary diagnostic services, special dietary treatment as prescribed by a physician and follow-up counseling for the patient and his or her family through contracts with specialty clinics and local agencies. Five cystic fibrosis centers, three metabolic clinics, one sickle cell comprehensive care center, one genetics center, and a local health department receive these contracts.

3. Development of Educational Materials--Enabling Services--Pregnant women and families with infants.

The Education Subcommittee of the NBS Advisory Group explored mechanisms to increase provider knowledge and awareness of the screening process. Based on recommendations of the subcommittee, a two-part webcast series was developed and presented live in September, 2007. The series was heavily promoted and a large number of providers viewed one or both webcasts. The series is now archived and available for viewing. Topics of the webcast included a history of NBS in Wisconsin, how to properly draw and prepare a sample, the role of the primary care provider, and how to talk to parents about the screen. The subcommittee also initiated quarterly newsletters to birth hospital coordinators with regular updates and reminders about newborn screening.

The Wisconsin NBS Program continues to participate in the HRSA "Region 4 Genetics Collaborative" grant with Wisconsin representatives in all workgroups. The regional collaborative allows states to share expertise in new technologies and best practice models to maximize available newborn screening resources.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Newborn Screening			X	
2. Diagnostic Services	X			

3. Development of Educational Materials		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Newborn Screening--Population-Based Services--Infants

The Wisconsin NBS Program currently screens all infants for 47 congenital disorders. In 2008, on the recommendations of the NBS Advisory Group, the Program discontinued screening for malonic acidemia and initiated screening for Severe Combined Immunodeficiency (SCID). Wisconsin is the first NBS Program in the nation to screen for SCID. Mechanisms for effective confirmatory testing and follow-up are also in place. An Immunodeficiency Subcommittee of the Newborn Screening Advisory Group has been established and will meet for the first time in the first half of 2008.

In March 2008, a Newborn Screening Coordinator was hired to coordinate Congenital Disorders Programming at the Division of Public Health, a role previously assumed by the State Genetics Coordinator. The NBS Coordinator will work with contracted agencies to promote and improve the NBS Program.

The NBS Program is working with the Wisconsin Hearing Screening Program, Vital Records, and the Birth Defects Surveillance System to link newborn screening data with other birth data. An infant's newborn screening card number will be included on the birth certificate and, in the future, will be used to link the results to other data.

c. Plan for the Coming Year

1. Newborn Screening--Population-Based Services--Infants

In 2009, all infants born in Wisconsin will continue to be screened at birth for a minimum of 47 congenital disorders.

The NBS Advisory Group and its Cystic Fibrosis, Metabolic, Hemoglobinopathy, Endocrine, Immunodeficiency, and Education subcommittees will meet at least biannually to advise the Department regarding emerging issues and technology in NBS.

2. Diagnostic Services--Direct Health Care Services--Infants

The Department will implement a paper-based tracking system for NBS dietary services in preparation for a web-based system. Tracked services will include the provision of dietary formulas and medical food products to children with conditions screened for by NBS by dietitians at contracted specialty centers.

3. Development of Educational Materials--Enabling Services--Pregnant women and families with infants.

The NBS Advisory Group Education subcommittee will educate the public and medical providers about Severe Combined Immunodeficiency (SCID) and its addition to the newborn screening panel. The subcommittee will continue to improve communication with the NBS program and hospitals through e-newsletters and other means as the NBS laboratory moves to 7-day-a-week

operations. The subcommittee will develop a module for childbirth educators about newborn screening to be presented to parents-to-be during childbirth education classes.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	67.6	68.6	69.6	70	70.5
Annual Indicator	66.6	66.6	66.6	65.3	65.3
Numerator	47819	47819	47819	132074	132074
Denominator	71816	71816	71816	202257	202257
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	71	71.5	72	72.5	71

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
1. Family Support Services--Enabling Services--CYSHCN

In 2007, the following services were provided: 87 families were matched through the WI Parent to Parent Program; 73 families received health education through Family Voices of WI (FVW); and 1,585 families received individual information and assistance through the five Regional CYSHCN Centers and their subcontracted agencies, which provided three primary methods for enhancing the capacity of parents to be decision makers, partners and leaders and offer parents an avenue to develop an informal network of support. For the first time, non-English speaking families were trained to be Parent to Parent support parents and efforts to identify match parents began. In collaboration with the MCB Integrated Services grant (WISC-I), 120 families with complex health benefits challenges received intensive health benefits counseling from ABC for Health, a non-profit health advocacy firm in Madison.

2. Coordination with Family Leadership and Support--Population-Based Services--CYSHCN

In 2007, the CYSHCN Program contracted with FVW to provide: a newsletter, which is distributed

both electronically and hard copy, three times per year; technical assistance to Regional Centers; policy updates; and health benefits training targeting CYSHCN from under-represented populations. The outreach to underserved populations resulted in non-English speaking families receiving both Parent to Parent and Family Voices trainings and materials in Spanish.

3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program--Infrastructure Building Services--CYSHCN

Parents continued to be utilized in a variety of advisory capacities including: the MCH and CYSHCN Programs and FVW co-facilitated both the strategic planning for Wisconsin's Medical Home Spread and a listening session for parents at the annual Circles of Life Conference. Each Regional Center and Family Voices support parents to be linked to councils at the local, regional or state levels. At the listening session we learned that while only 25-33% of the attendees were aware of the Regional CYSHCN Centers, parents who had used the centers or Parent to Parent found these services valuable. The staff at the Regional Centers, Family Voices and Parent to Parent all serve on a range of councils and committees to advance the performance measure to address families as partners in decision-making at all levels. In 2007 the Regional Center directors delineated the collective council representation and identified parent representation, duplication, gaps and made plans for refinement.

CYSHCN program staff provided input at a National gathering, "Family Perspectives on Autism Service Guidelines for the Medical Home", to forward the Autism Service Guidelines and system requirements that were developed by a multi-disciplinary expert work group and were presented to the federal Interagency Autism Coordinating Committee. The guidelines address the core principles of an integrated and coordinated service system for autism services within and through the medical home. This meeting considered what it will take to influence national policy for improvement of systems of care for individuals with Autism Spectrum Disorders. The Autism Service Guidelines articulate best practice for serving children with ASD and their families in medical home primary care practices, working in collaboration and with the support of other professionals and professional organizations, government, health, education, and social services.

4. Family Partnerships--Infrastructure Building Services--CYSHCN

In 2007, parents of CYSHCN were part of the staff of the State CYSHCN Program, all five Regional Centers, Parent to Parent and Family Voices, making parents integral to the ongoing decision-making, program implementation and evaluation. CYSHCN partners have formed a Collaborators Network which communicates regularly to share resources, problem solve difficult issues and identify unmet needs in the state. A subgroup of the Network consists of staff providing information and referral (I & R) services to families and this group began monthly teleconferences and a listserv in 2007 to increase the level of communication. Family Voices tracks policies that impact families and was effective in bringing the needs of CYSHCN on waiting lists to the attention of policy makers resulting in new funding for long term care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Family Support Services		X		
2. Coordination with Family Leadership and Support			X	
3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program				X
4. Family Partnerships				X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

1. Family Support Services--Enabling Services--CYSHCN

In 2008, families receive parent matching, training and information and assistance. In April, WISC-I's intensive health benefits counseling with families ended, yet ABC for Health continues to provide general supports to the Network.

2. Coordination with Family Leadership and Support--Population-Based Services--CYSHCN

In 2008, the CYSHCN Program contracts with FV to provide: a newsletter three times per year; listserv; policy updates; and health benefits training for under-represented populations including Great Lakes Inter-Tribal Council's (GLITC) parents.

3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program--Infrastructure Building Services--CYSHCN

Parents continue to be utilized in a variety of advisory capacities through Regional Centers and Family Voices who link parents to committees, with an emphasis on outreach to underserved parents. A new Regional Center brochure was developed with family input at every step.

4. Family Partnerships--Infrastructure Building Services--CYSHCN

In 2008, parents continue to be part of the staffing at all levels of the CYSHCN Program. The CYSHCN Collaborators Network met at GLITC to learn more about Indian Health Services and Tribal cultures, and the implications for parents as decision makers. Family Voices tracks policies that impact families and was effective in bringing the needs of CYSHCN on waiting lists to the attention of policy makers.

c. Plan for the Coming Year

1. Family Support Services--Enabling Services--CYSHCN

In 2009, families will continue to be matched through the WI Parent to Parent Program, receive health education through FVW and will be offered information and assistance through the five Regional Centers. ABC for Health will continue to provide general supports to the CYSHCN Collaborators Network around the complexity of health insurance eligibility and benefits.

2. Coordination with Family Leadership and Support--Population-Based Services--CYSHCN

In 2009, the CYSHCN Program will continue to contract with FVW and dove-tail these activities with those of the Family to Family Health Information Network grant that FVW has through MCHB. FV will provide the following: a newsletter three times per year; health benefits training targeting CYSHCN from under-represented populations; unmet needs collection, analysis and dissemination; and assistance in Regional Center transition to adult health care trainings. FVW will continue to build a parent network as it addresses the above activities. The outreach to underserved populations continues to target Southeast Asian, African American, Hispanic, and Native American families.

3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program--Infrastructure Building Services--CYSHCN

Parents will continue to be utilized in a variety of advisory capacities through Regional Centers

and Family Voices who support parents to be linked to a council or committee at a local, regional or state level. The staff at the Regional Centers, Family Voices and Parent to Parent will continue to serve on a range of councils and committees to advance the CYSHCN NPO on parents as decision makers.

4. Family Partnerships--Infrastructure Building Services--CYSHCN

In 2009, parents will continue to be part of the staffing at all levels of the CYSHCN Program. The CYSHCN Collaborators Network will meet annually and by conference call so that the CYSHCN system for building parents as partners can be coordinated across programs. The I & R group continues to benefit from regular contact so that the staff understand the ever changing health benefits system and can educate families about community resources and insurance eligibility and benefits. Family Voices will continue to track unmet needs in collaboration with the CYSHCN partners so that family needs are articulated on a policy level.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	58.1	59.1	60.1	60.5	61
Annual Indicator	57.1	57.1	57.1	54.6	54.6
Numerator	98758	98758	98758	110432	110432
Denominator	173017	173017	173017	202257	202257
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	55	57	58	59	60

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
1. Medical Home Education and Training--Population-Based Services--CYSHCN

In conjunction with the Wisconsin Integrated Systems for Communities Initiative (WISC-I) grant, the CYSHCN Program held the third annual Medical Home Summit on November 15, 2007 with

138 registered participants. The plenary panel on care coordination, facilitated by a Regional Center, gave participants concrete strategies for change. The panel on Wisconsin-specific initiatives, facilitated by Family Voices of WI (FVW), addressed: children's long term care; local community health centers; electronic health records; and the role of state legislators. Sectionals on developmental screening, outcomes/financing, transition from pediatrics to adult health care, partnership building and links to community care were all addressed with state leaders in these areas.

2. Medical Home Outreach--Population-Based Services--CYSHCN

As part of Spread, dissemination of the concepts of Medical Home continued to be integrated in the Wisconsin Sound Beginnings (Early Hearing Detection and Intervention) and Congenital Disorders (blood spot newborn screening) Programs. The Medical Home Toolkit has been disseminated using a variety of methods, including face-to-face presentations at primary practice offices. The Toolkit had approximately 1,500 visits/month in 2007. The Medical Home Local Capacity Building grants, administered by each Regional CYSHCN Center, were in the second year of the first cycle. As part of the WISC-I grant, five medical home quality improvement mini-grants were awarded to primary practice teams in three regions of the state. The pre and post Medical Home Short Index showed improvements in key areas. Distribution has included the Tips for Families/Providers brochures through CYSHCN Collaborators network.

3. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

The Regional CYSHCN Centers continued to develop relationships with individual primary care providers in their region to assist with community connections, information and referrals. The state CYSHCN Program continued its collaborative activities with the National Medical Home Autism Initiative, the Division of Health Care Financing and the two pediatric tertiary care facilities in Wisconsin. Statewide spread planning continued with FVW. The Medical Home Tertiary Care Transition Learning Collaborative, supported through the WISC-I grant, partnered with other CYSHCN initiatives as it brought together interdisciplinary teams to hear from youth, parents and medical providers about transitioning from pediatrics to adult health care. Product development and data collection were continued from the previous year.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Medical Home Education and Training			X	
2. Medical Home Outreach			X	
3. Medical Home and Community Supports				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Medical Home Education and Training--Population-Based Services--CYSHCN

In 2008, the CYSHCN Program will continue Medical Home Toolkit improvements adding new resources from local grantees and learning collaborative participants. FVW and Regional Centers will continue to integrate Medical Home concepts and strategies into their information-sharing and training.

2. Medical Home Outreach--Population-Based Services--CYSHCN

The Medical Home Local Capacity Building grants, administered by each Regional Center, are in the first year of the second cycle. The annual grantee meeting will focus on cultural competency as integral to Medical Home. Key Medical Home spread activities, which began with WISC-I (which ended in April) will be continued through Regional Centers and the Practice Group on Health.

3. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

The Regional CYSHCN Centers will reach out to new individual providers in their regions to assist with community connections, information and referrals. Partnerships strengthened through WISC-I will continue to develop as the Regional Centers assume responsibility for follow-up with the learning collaborative with tertiary care specialty clinics. The CYSHCN Program and the National Medical Home Autism Initiative partner to share information, support practice sites, and participate in state and regional planning.

c. Plan for the Coming Year

1. Medical Home Education and Training--Population-Based Services--CYSHCN

The CYSHCN Program will continue to implement improvements to its Medical Home Toolkit to include new resources and in response to product evaluation data. Family Voices and Regional Centers will continue to integrate Medical Home concepts and strategies into their information-sharing and training.

2. Medical Home Outreach--Population-Based Services--CYSHCN

The Medical Home Local Capacity Building grants, administered by each Regional Center, will be in the second year of the second cycle. The annual grantee meeting will further strengthen Medical Home spread and quality improvement strategies. Regional Centers will promote early screening and identification to their grantees and link them to training and materials if needed.

3. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

The CYSHCN State Program and its contracted agencies will continue to promote Medical Home spread and offer technical assistance supports through work with key partners on the local, regional and state levels. Promotion will include targeting children's hospitals and pediatric units within hospitals, primary care practices, local health departments, state and community partners, and parents who have CYSHCN. The CYSHCN Program will continue to facilitate discussion with Health Care Access and Accountability and the two pediatric tertiary care facilities in Wisconsin to explore the spread of reimbursement for care coordination for children with complex medical needs.

The Regional CYSHCN Centers, in collaboration with Birth to Three and physician champions will implement a training in each region that targets primary care medical providers to adopt early screen practices, validated tools and links to community resources.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	66.6	67.6	68.6	69	69.5
Annual Indicator	66.6	66.6	66.6	63.0	63.0
Numerator	117664	117664	117664	127442	127442
Denominator	176641	176641	176641	202257	202257
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	64	65	66	67	68

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
1. Health Benefits Services--Enabling Services--CYSHCN

In collaboration with funding through Wisconsin Integrated Systems for Communities Initiative (WISC-I) grant, the five Regional CYSHCN Centers completed a Health Benefits Self-Assessment. Training needs were identified and addressed by ABC for Health through monthly conference calls and webcasts.

2. Access to Health Insurance--Infrastructure Building Services--CYSHCN

Three of the five Regional CYSHCN Centers co-facilitated Health Watch Committees with a focus on oral and mental health.

3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN

Regional Oral Health Consultants continued to provide oral health prevention programs in the (5) DPH public health regions. Working within local communities the consultants utilized an interdisciplinary approach to case management and treatment services focusing on CYSHCN. 'Smile Abilities' was a presence at the Circles of Life Conference providing information and support to families.

4. Mental Health Services for CYSHCN--Infrastructure Building Services--CYSHCN

The CYSHCN Health Promotion Consultant serves on the DHFS Infant Mental Health Leadership Team which lends guidance to the Wisconsin Alliance for Infant Mental Health initiative on implementing the Wisconsin Infant and Early Childhood Mental Health Plan. DHFS created an

Infant Mental Health Leadership Team to address the infant mental health goal in the Governor's Kids First Initiative supporting the Infant Mental Health and Early Childhood Plan for Wisconsin. As part of that plan that addresses access to services, the following initiatives were begun in 2007: development of a service plan for children with a DC:0-3R diagnoses; implementation of a mental health screen for children in the child protective services system; development and implementation of provider training on early child development; and the provision of technical assistance regarding raising emotionally attached children to early childhood community groups.

5. Family Education and Training--Enabling Services--CYSHCN

The CYSHCN Program contracted with Family Voices of Wisconsin (FVW) to implement health benefits and community supports training for parents in each of the five DPH regions. The trainers were parents of CYSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Health Benefits Services		X		
2. Access to Health Insurance				X
3. Access to Dental Care Services				X
4. Mental Health Services for CYSHCN				X
5. Family Education and Training		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Health Benefits Services--Enabling--CYSHCN

The Regional CYSHCN Center staff completed the Health Benefits post self-assessment. ABC for Health is reviewing the information and will continue training and technical assistance on the Badger Care Plus system.

2. Access to Health Insurance--Infrastructure Building Services--CYSHCN

The Regional Centers continued one of their core services in assisting families to secure health insurance through information, referral and follow-up.

3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN

Expansion continued for the HRSA funded Wisconsin Community-based System of Oral Health for CYSHCN. Through collaboration with the regional CYSHCN centers, public/private schools, and Head Start, the Regional Oral Health Consultants provide case management, education, and treatment follow up for at least 25 families.

4. Mental Health Services for CYSHCN--Infrastructure Building Services--CYSHCN

The "2007 Annual Report and Fact Sheet for the Dept. Infant Mental Health Leadership Team" was competed and forwarded to the Governor. This Team's charge is to identify ways that DHFS can weave infant mental health practices and principles into the Departments' programs and services.

5. Family Education and Training--Enabling Services--CYSHCN

Parent trainers of FVW continue to offer family members training regarding health insurance and community supports with the support of the CYSHCN Regional Centers.

c. Plan for the Coming Year

1. Health Benefits Services--Enabling Services--CYSHCN

ABC for Health is reviewing results of the post self-assessment and will the provide analysis. The CYSHCN Program and Medicaid are planning a web cast training on BadgerCare Plus. ABC for Health will continue its web casts and case study calls through the WISC-I grant period and questions regarding complex legal issues will be referred to ABC for Health.

2. Access to Health Insurance--Infrastructure Building Services--CYSHCN

The Regional Centers will continue one of their core services in assisting families to secure health insurance through information, referral and follow-up. Two of the Regional Centers maintain a local Health Watch Committee and two attend local meetings, to identify and address health related needs for CYSHCN. The Southeast Region has a focus on the BadgerCare Plus Program.

3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN

The Department, in collaboration with the Children's Health Alliance of Wisconsin (CHAW), received funding through HRSA for the Wisconsin Community-based System of Oral Health for Children with Special Health Care Needs. Seven Regional Oral Health Consultants will be placed within the (5) DPH regions. They will work directly with the regional CSYHCN centers providing technical assistance, program development , case management and prevention services to CYSHCN and their families. The grant will allow for the hands on training of dental health personnel to reduce a major barriers to care for CYSHCN.

4. Mental Health Services for CYSHCN--Infrastructure Building Services--CYSHCN

The Wisconsin Infant Mental Health Leadership Team selected the following goals for 2008-2010 to address the service needs of children to include: standardization of screening objectives across diverse divisions and systems of care; integration of children's mental health and primary health care services; full implementation of DC:0-3R in Wisconsin; and training and technical assistance on DC:0-3R.

In addition, the Children's Committee of the Wisconsin Mental Health Council will be addressing the shortage of child and adolescent psychiatrists including parity issues. With 8.2 psychiatrists per 100,000 youths, Wisconsin is near the national average for psychiatrists however, it is below the 14.4 needed for optimum patient care. Nearly 90,000 school-age children in Wisconsin have a mental illness. Only 15.6% of these children received public mental health services in 2005. In addition, the Wisconsin Autism Developmental Disability Monitoring (ADDM) Network Project reported that 5.2 per 1,000 children in Wisconsin have an Autism Diagnosis and are in need of mental health services.

5. Family Education and Training--Enabling Services--CYSHCN

Parent trainers of FVW will continue to offer family members training regarding health insurance and community supports with the support of the Regional Centers.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	81.7	82.7	83.7	84	84.5
Annual Indicator	80.7	80.7	80.7	90.0	90.0
Numerator	57768	57768	57768	182031	182031
Denominator	71620	71620	71620	202257	202257
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	91	91	92	92	93

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
1. Access to Individual/Household Services--Enabling Services--CYSHCN

Individuals, families, and providers who contact the five Regional CYSHCN Centers and their subcontracted agencies received direct assistance, referrals to other professionals, or other interventions by Center and local staff. In 2007, according to the data entered in the MCH Secure Public Health Electronic Record Environment (SPHERE), there were 4,542 CYSHCN-funded contacts and services provided, with 1,585 individual/household interventions and 2,817 brief contacts. "Brief contacts" include consultations that are face-to-face, on the telephone, and/or in writing.

2. Community Based Services--Population-Based Services--CYSHCN

This year the Northeast Regional CYSHCN Center terminated their contract due to budgetary constraints and an RFP process was implemented to identify and secure a new vendor. Children's Hospital of Wisconsin-Fox Valley in Neenah was awarded the contract to begin January 1, 2008. This vendor brings a high level of content expertise, institutional commitment, and links to the community.

Partnerships at the local, regional and state levels were advanced through co-sponsored events,

established cross-referral plans and identified target populations that are vulnerable to falling through the cracks. The CYSHCN and its Regional Centers have delineated the key committees and conferences where CYSHCN representation is critical and an outreach plan specifies responsibilities over the state.

3. Planning and Implementing Community Based Projects--Infrastructure Building Services--CYSHCN

Working in partnership with other funding sources, the WI Title V CYSHCN Program continued to plan and implement statewide training of nine WIC nutritionists who work with Regional Centers to improve nutritional services for CYSHCN.

Wisconsin was awarded a MCH Targeted Oral Health Service Systems Grant entitled "Wisconsin Community-based System of Oral Health for CYSHCN." This four year grant is administered through the Children's Health Alliance of Wisconsin.

Collaboration with the WISC-I grant led to establishment of the CYSHCN Collaborators Network comprised of the CYSHCN-funded entities; the five Regional Centers, Family Voices, Parent to Parent, First Step, GLITC, ABC for Health, the oral health coordinators and the WIC nutritionists. This group met regularly by phone and once a year face-to-face.

The Title V CYSHCN Program continues to work collaboratively with many partners to assure that that children and youth with special health care needs are identified early, receive coordinated care and that their families have access to the supports they need. These collaborative partnerships include: Parent to Parent; Family Voices of Wisconsin; Great Lakes Inter Tribal Council; ABC for Health; First Step; WI Chapter of the AAP and WAFP; early intervention ICC; Wisconsin Early Childhood Collaborating Partners; Department of Public Instruction's Wisconsin Statewide Parent-Educator Initiative; the Parent Training and Information Center- WI FACETS; statewide Wisconsin Asthma Coalition; Wisconsin Infant Mental Health Association; and the Circles of Life Planning Conference.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Access to Individual/Household Services		X		
2. Community Based and System Based Services			X	
3. Planning and Implementing Community Based Projects				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Access to Individual/Household Services--Enabling Services--CYSHCN

In 2008, the five Regional Centers and their delegate agencies continue to provide information and assistance to families and providers. Local Health Departments (LHD) continue to have the option of providing these serves at a local level. Families are linked to trainings and parent support opportunities to meet their needs.

2. Community Based and System Based Services--Population-Based Services--CYSHCN

Regional CYSHCN Centers administer 12 Medical Home local community capacity grants allowing communities to build upon assets and develop local systems of care for CYSHCN.

In 2008, the new NE Regional Center has hired a Director, previously the Director of the National Autism Medical Home Initiative, who brings expertise in CYSHCN.

3. Planning and Implementing Community Based Projects--Infrastructure Building Services--CYSHCN

The Regional Centers have begun to meet with the regional oral health consultants from the Wisconsin Community-based System of Oral Health for CYSHCN. Centers continue to access their WIC-nutrition regional consultants and an all-day WIC pre-conference session in June will provide an opportunity for more dialogue on partnership.

Regional Centers continue to respond to local requests for training, outreach, and assistance. The Collaborators Network continues to share resources, problem-solve, and cross-refer.

c. Plan for the Coming Year

1. Access to Case Management, Consultation and Referral and Follow-Up Services--Direct Health Care Services--CYSHCN

In 2009, the five Regional CYSHCN Centers and their delegate agencies will continue to provide information and assistance to families and providers. Families will be linked to trainings and parent support opportunities to meet their needs. The LHDs will again have the option to choose serving CYSHCN through Regional Center subcontracts and/or MCH Consolidated Contracting.

2. Community Based and System Based Services--Population-Based Services--CYSHCN

Regional Centers will continue to administer Medical Home local community capacity grants which will allow communities to build upon resources, develop local systems of care for CYSHCN and reach out to underserved populations. LHDs will have an option to select a systems objective to spread Medical Home through both the consolidated contracts and regional center subcontracts.

3. Planning and Implementing Community Based Projects--Infrastructure Building Services--CYSHCN

In partnership with other funding sources, the CYSHCN Program will plan and implement the following projects during 2009: continue to implement the Regional CYSHCN Center model; use the statewide GAC system to manage and monitor the objectives and fiscal operation of the CYSHCN Program; and provide technical assistance to recipients of local community capacity grants to monitor, evaluate and support the objectives of the grant. The Collaborators Network will continue to share resources, problem-solve, and cross-refer.

As an outcome of the annual all-staff 2008 CYSHCN Collaborators Network strategic planning meeting, the CYSHCN Program will follow-up on recommendations to increase our program's visibility, focus more attention on early identification and screening and broaden the stakeholder group that meets regularly. In 2009, plans will be explored to sponsor a key stakeholder leadership meeting whereby leaders from key agencies and community partners would come together to talk about and plan for our shared population of CYSHCN and how we can work together to support this population.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	6.8	7.8	7.8	8	7
Annual Indicator	5.8	5.8	5.8	44.5	44.5
Numerator	64727	64727	64727	90004	90004
Denominator	1116374	1116374	1116374	202257	202257
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	50	52	54	55	56

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
Data issues: 1)The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. 2)We revised our objectives for 2007 - 2011 to realistically assess this measure; however, Wisconsin does not have state-specific data for this measure and we rely on SLAITS.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
1. State Partnership Building--Infrastructure Building Services--CYSHCN

The Statewide Transition Consortium and Department of Public Instruction's (DPI) transition advisory group merged to form a Community of Practice on Transition (CoT). This model of shared work is national and builds on what had been in place. The primary outcome is that the DPI group had a strong educational focus and the CYSHCN-sponsored Consortium has a health focus and now all key stakeholders are at the same table to share resources, identify gaps and work together through practice groups to get work accomplished. Practice teams have been established around CYSHCN-specific topic areas and the CYSHCN Program assumes a lead role on the Practice Group on Health.

The Youth Advisory Committee, funded through the Wisconsin Integrated Systems for Communities Initiative (WISC-I) grant, finalized its work and provided feedback to the CYSHCN program on its materials and program activities.

A new round of Community Connectors mini-grants was started in 2007 and continued to build community supports for youth in transition.

The CYSHCN Program continued to utilize the WISC-I grant to support a Transition Tertiary Learning Collaborative and the teams continued to work on their products, which are posted on the Medical Home Toolkit.

2. Training and Outreach--Training Infrastructure Building Services and Outreach Population-Based Service--CYSHCN

Regional CYSHCN Centers worked with school nurses to share strategies for implementing health into the IEP, using a set of training materials that the Centers developed and disseminated.

3. Access to Transition Information--Enabling Services--CYSHCN

Quality transition information was disseminated to YSHCN, their families and providers, through the transition listserv, referral and follow-up services, and in partnership with the new Family Voices of Wisconsin's, Family-to-Family Health Information Center.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. State Partnership Building				X
2. Training (IB) and Outreach (PBS)			X	X
3. Access to Transition Information		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. State Partnership Building--Infrastructure Building Services--CYSHCN

The CYSHCN Program continues to support the CoT in collaboration with DPI. The Regional Centers will continue to support transition activities at the local and regional level through their involvement in the CoT and practice teams on CYSHCN-specific areas. The CYSHCN Program leads the Practice Group on Health. While WISC-I ends in 2008, the CYSHCN Program will sustain integration initiatives through Regional Center contracts and state managed activities. The state will be on the steering group for the statewide CoT. The Medical Home Transition Learning Collaborative with youth, families, tertiary care providers, and administrators will come to a close and outcomes from their work on transition from pediatric to adult care services will be disseminated. The collaborations will be continued through regional and state partnerships.

2. Outreach and Training--Training Infrastructure Building Services and Outreach Population-Based Services--CYSHCN

A CoT workgroup is adapting the Pennsylvania health care checklist for use in WI. The original HRTW Transition to Adult Health Care training curriculum was reviewed by key stakeholders and will be revised in the coming year with support from additional funding sources.

3. Access to Transition Information--Enabling Services--CYSHCN

The CYSHCN Program will continue to disseminate quality information about transition.

c. Plan for the Coming Year

1. State Partnership Building--Infrastructure Building Services--CYSHCN

The CYSHCN Program will continue to support the Community of Practice on Transition in collaboration with Department of Public Instruction. This collaborative group has representatives from over 40 state programs and community partners with transition-related interests. The state CYSHCN Program is part of the core leadership team for the CoT. The Regional CYSHCN Centers will continue to support transition activities at the local and regional level through their involvement in the CoT, with practice teams on CYSHCN-specific areas. In 2009, the CYSHCN Program will sponsor an annual CoT meeting with a focus on health. The Health care Checklist will be finalized, printed and disseminated to key stakeholders, including posting it on the WI Medical Home Toolkit and sharedwork.org websites.

2. Outreach and Training--Training Infrastructure Building Services and Outreach Population-Based Services--CYSHCN

The Transition to Adult Health Care curriculum will be printed and disseminated to further prepare YSHCN, their families and providers for the move from pediatrics to adult health care. The Regional CYSHCN Centers and Family Voices parent trainers will receive a train-the-trainer session on the revised Health Care Transition curriculum. Following this training, there will be opportunities for youth, parents, and providers to go to a training, receive targeted support in a clinical or one-to-one setting.

3. Access to Transition Information--Enabling Services--CYSHCN

The CYSHCN Program will continue to disseminate quality information about transition to YSHCN, their families and providers. This will occur through the transition listserv, referral and follow-up services at the Regional CYSHCN Centers and in partnership with the Family Voices of Wisconsin, Family-to-Family Health Information Center. One medical home local capacity grant supports youth and parent training and includes health care transition information. The Wisconsin Medical Home Toolkit will continue to serve as a source of CYSHCN transition information and resources for medical providers.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	79	83	83.5	83.2	83.4
Annual Indicator	82.6	83.0	83.0	82.3	86.8
Numerator	727	730	730	724	764
Denominator	880	880	880	880	880
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	83.5	83.6	83.7	83.7	83.7

Notes - 2007
These data are from 2006 and entered as provisional. Data for 2007 will not be available until late 2008. The most recent (entered as 2007, but 2006 data) from the National Immunization Survey show that Wisconsin's immunization estimated coverage rates for 4 DTaP, 3 Polio, 1 MMR, 3 Hep b, and 3 hib among kids 19-35 months of age rose from 83.0% in 2005 to 86.8% in 2006. This increase may be due to acceptance and use of the Wisconsin Immunization Registry (WIR).

Notes - 2006
Data issues: The most recent data from the CDC is from the National Immunization Survey (www.cdc.gov/nip under "data and statistics" and represent calendar year 2005. The vaccine coverage estimates for 2005 among Wisconsin children who were 19 to 35 months of age with 4 DTaP, 3 Polio, 1 MMR, 3 Hep b, and 3 hib doses was 82.2%. This is a slight decline from last year's estimate. The NIS states: "Remember, NIS provides estimates that include a margin of error. That's because it is a sample survey. Even though the sample is quite large -- about 30,000 children (nationally), it is just one of many possible samples. A different sample would result in a different--but probably quite similar estimate. The drop could be due to chance." Although the national goal for 2010 is 90%, we have kept our 2010 and 2011 objectives at the same level based on program expertise.

Notes - 2005
Data issues: Due to fiscal constraints, CDC's National Immunization Survey was not completed for SFY 2005 (7/1/04-6/30/05), therefore, we used 2004 data for 2005.
Although the national goal for 2010 is 90%, we have slightly revised our objectives to reflect 2004's data and program expertise.

a. Last Year's Accomplishments
1. Providing, Monitoring, and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

Data required for this measure is provided annually by the State Immunization Program. The Immunization Program's template objectives for the local health departments for the past several years have been to use the Wisconsin Immunization Registry (WIR), and establish population-based objectives to raise immunization levels of all preschool children with series complete immunization (4,3,1,3,3,1) by 24 months of age or the 4th booster dose of DTaP vaccine by 19 months of age. The latest full year's data from the NIS show that Wisconsin's immunization estimated coverage rates among kids 19-35 months of age rose from 82.2% in 2005 to 86.8% in 2006. Varicella is also included as part of the CDC standard for series completion but not included in above rate.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants, and children, including CYSHCN

The State Immunization Program continues to partner with the Title V MCH/CSHCN Program, LHDs, the WIC Program, the Medicaid Program, tribes, and CHCs. WIR plans to support and maintain WIC sites as registry program participants. A dramatic increase in Wisconsin rates may be due in part to acceptance and use of the Wisconsin Immunization Registry.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization

Program--Infrastructure Building Services--Pregnant women, mothers, infants, and children, including CYSHCN

National and international circumstances that result in subsequent policy changes or clinical practices are tracked by the State Immunization Program. Information updates were shared by the state Immunization Program with key partners as indicated at spring communicable disease seminars held in each of the five DPH regions.

4. Tracking Children at Age Two Enrolled in Medicaid--Population-Based Services--Children, including CYSHCN

The statewide tracking of Medicaid-enrolled children at age two with up-to-date immunizations continued. The goal remains at 90% to reflect the national goal for 2010.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing, Monitoring, and Assuring Immunizations	X			
2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)				X
3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program				X
4. Quality Improvement of Vaccines for Children Program				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Providing, Monitoring, and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

Title V funding continues to support LHDs primary prevention activities that include immunization monitoring and support compliance with State Immunization Program funds.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants, and children, including CYSHCN

The State Immunization Program will continue partnerships with the Title V MCH/CYSHCN Program, LHDs, WIC Program, the Medicaid Program, tribes, and CHCs. WIR will expand as policy changes dictate.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

National and international circumstances that result in recommended changes in the immunization schedule are tracked by the State Immunization Program.

4. Quality Improvement of Vaccines for Children Program--Infrastructure Building Services--Children, including CYSHCN

QI efforts for providers in 2008 occur through site visits by Immunization Program personnel to 25% of all Vaccine for Children sites in Wisconsin. One of the topics covered is provider participation with the WIR and the appropriate use of the reminder/recall function.

c. Plan for the Coming Year

1. Providing, Monitoring and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

Title V, MCH program funding will continue to support LHDs' primary prevention activities that include immunization monitoring and support compliance with State Immunization Program funding requirements. Data required to enable MCH to monitor and report this measure will continue to be provided by the State Immunization Program.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants, and children, including CYSHCN

The State Immunization Program continues to partner with the Title V MCH/CYSHCN Program, LHDs, the WIC Program, the Medicaid Program, tribes, and CHCs.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

National and international circumstances that result in recommended changes in the immunization schedule will continue to be tracked by the State Immunization Program during 2009 and policy sharing will occur as appropriate. Starting in the fall semester of 2008-2009 school year, new vaccine requirements go into effect. All students in grades K, 6 and 12 will be required to receive the 2nd dose of varicella vaccine and students in grades 6, 9 and 12 will be required to receive a dose of the adolescent Tdap vaccine. Finally, children entering licensed day care centers after September 1, 2008 will have to provide evidence of having receive pneumococcal vaccine.

4. Quality Improvement of Vaccines for Children Program--Infrastructure Building Services--Children, including CYSHCN

During 2009 quality improvement efforts for providers will be maintained through site visits by Immunization Program personnel to at least 25% of all Vaccine for Children sites in Wisconsin.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	15.7	15.4	15.1	14.8	14.7
Annual Indicator	15.5	14.9	14.9	15.6	15.6
Numerator	1861	1765	1776	1840	1840
Denominator	119722	118370	119124	118012	118012
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	14.9	14.8	14.7	14.6	14.5

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Data notes: There were 92 births to teen <15 years in Wisconsin in 2006. Source: Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services. Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 04/7/2008.
Denominator: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish, Population Module, accessed 03/21/2007.

Notes - 2005
Source: Numerator: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 04/10/2007.
Denominator: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish, Population Module, accessed 03/21/2007.

a. Last Year's Accomplishments
1. Title V Abstinence Education--Population-Based Services--Adolescents

The Governor of Wisconsin decided not to reapply for Title V Abstinence Education funds beyond 6-30-07. This decision related to requirements for grantees to adhere to all 8 elements in the definition of abstinence education specified in Title V of the Social Security Act. The Abstinence Education Program Closeout was effective on December 21, 2007.

2. Milwaukee Adolescent Pregnancy Prevention (MAPP) Patrnership--Enabling Services--Adolescents

DPH successfully completed an RFP and contract award for a new initiative entitled; The Milwaukee Adolescent Pregnant Prevention Partnership. This four agency Milwaukee collaborative is designed to increase the Family Planning Waiver Enrollment for African American teens ages 15 to 19.

3. Education and Outreach--Enabling Services--Adolescents

A Parent and Teen Resource Guide and Video was developed focusing on influential roles of parents.

4. Data--Infrastructure Building Services--Adolescents

The third edition of the Wisconsin Youth Sexual Behaviors Data Outcomes Report was published highlighting trend data for abstinence, HIV/STD and teen births.

5. State Adolescent Pregnancy Prevention Committee--Infrastructure Building Services--Adolescents

A Department of Health and Family Services-Division of Public Health STD Program staff became Co-Chair to the State Adolescent Pregnancy Prevention Committee.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V Abstinence Education			X	
2. Milwaukee Adolescent Pregnancy Prevention Partnership		X		
3. Education and Outreach		X		
4. Data				X
5. State Adolescent Pregnancy Prevention Committee				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Education and Outreach--Enabling Services--Adolescents

A joint Department of Health and Family Services and Department of Workforce Development press release was developed to acknowledge National Teen Pregnancy Prevention Month. The release encourages teens across Wisconsin to make responsible decisions about their health and highlights Wisconsin's effort to reduce disparities in teen pregnancy.

2. Milwaukee Adolescent Pregnancy Prevention Partnership--Enabling Services--Adolescents

The Milwaukee Adolescent Pregnancy Prevention Partnership is planning and implementing strategies to engage African American youth from non-traditional and ethnically diverse communities to become delivers of evidence-based teen pregnancy and STD prevention messages. The DPH Youth Policy Director administers the MAPP contract.

3. Data--Infrastructure Building Services--Adolescents

Work is beginning on the fourth edition of the Wisconsin Youth Sexual Behaviors Data Outcomes Report highlighting trend data for abstinence, HIV/STD and teen births.

4. Adolescent Pregnancy Prevention Committee--Infrastructure Building Services--Adolescents

The State's Adolescent Pregnancy Prevention Committee meets quarterly.

c. Plan for the Coming Year

1. Data--Infrastructure Building Services--Adolescents

The fourth edition of the Wisconsin Youth Sexual Behaviors Data Outcomes Report will be published highlighting trend data for abstinence, HIV/STD, and teen births.

2. Milwaukee Adolescent Pregnancy Prevention Partnership--Enabling Services--Adolescents

The Milwaukee Adolescent Pregnancy Prevention Partnership grantee will make significant numerical and qualitative inroads in increasing the Medicaid Family Planning Waiver as well as establish clear communication and coordination mechanism with Milwaukee organizations charged with responsibilities of teen pregnancy prevention, teen parenting and adolescent reproductive health services and advocacy.

3. Education and Outreach--Enabling Services--Adolescents

A Teen Pregnancy Prevention Press Release for the 2009 National Pregnancy Prevention Month will be completed.

4. Adolescent Pregnancy Prevention Committee--Infrastructure Building Services--Adolescents

The State's Adolescent Pregnancy Prevention Committee will continue to meet quarterly.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	49	49.5	50	50	50
Annual Indicator	47.0	47.0	47.0	47.0	47.0
Numerator	34134	34134	34134	34134	34134
Denominator	72626	72626	72626	72626	72626
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	50	50	50	50	50

Notes - 2007
Source: Numerator: calculated by taking 2001's indicator, the Wisconsin Division of Public Health"Make Your Smile Count" survey of third grade children, 2001-2002. Denominator: the number of third grade children enrolled in public and private schools. We are currently conducting another third grade survey, therefore, for next year we will have updated information/data.

Notes - 2006
Source: Numerator: calculated by taking 2001's indicator, the most recent Wisconsin Division of Public Health"Make Your Smile Count" survey of third grade children, 2001-2002. Denominator: the number of third grade children enrolled in public and private schools. Future data are dependent on funding for an additional survey.

Notes - 2005
Source: Numerator: calculated by taking 2001's indicator, the most recent Wisconsin Division of Public Health "Make Your Smile Count" suvey of third grade children, 2001-02. Denominator: the number of third grade children enrolled in public and private schools. Future data are dependent on funding for another survey.

a. Last Year's Accomplishments

1. Healthy Smiles for Wisconsin Seal-A-Smile Sealant Program--Direct Health Care Services--Children

In 2006/07 Maternal Child Health Block Grant funds were provided to 4 local agencies to provide dental sealants in school-based/community settings to all eligible children with non-carious, erupted first or second molars. Approximately 385 children were assessed and had sealants placed.

The Department contracted with Children's Health Alliance of Wisconsin (CHAW), the Title V grantee for statewide child health system building, to manage Health Smiles for Wisconsin: Seal-A-Smile initiative.

In 2006/07 21 community or school-based programs hosted 174 Seal-A-Smile (SAS) events. SAS screened 8,522 children and delivered sealants to 5,602 children. The program documented that 374 children with special health care needs were served. In addition to placing 15,287 sealants on permanent first molars, 6,724 children received topical fluoride treatments, 12,076 children received oral health education and 3,671 were referred for additional dental care. The SAS program average for sealant placement cost per child is $21.92, however the cost per cavity averted, according to the Center for Disease Control and Prevention health economists is $51.48.

2. Healthy Smiles for Wisconsin Oral Health Infrastructure Support--Infrastructure Building Services--Children--including CYSHCN

CHAW is actively involved in improving dental access and care through the Healthy Smiles for Wisconsin initiative. CHAW conducted regional meetings for Seal-A-Smile grantees. The CDC refined SEALS, a data collection software program and published Wisconsin's data.

3. Technical Assistance--Enabling Services--Children, including CYSHCN

Technical assistance was provided for 21 state-funded sealant programs through CHAW's Oral Health Project Manager. The Wisconsin state Chief Dental Officer and Public Health Dental Hygienist monitored the CHAW contracts to manage the CDC Disease Prevention Grant in School-Aged Children and the Healthy Smiles for Wisconsin Seal-A-Smile grants.

Over $190,000 in state GPR and HRSA Workforce grant funds were distributed to initiate 21 funded programs.

The Healthy Smiles for Wisconsin Coalition continued to promote oral health prevention through a steering committee, policy development committee and prevention/clinical care committee.

4. Oral Health Surveillance--Population-Based Services--Children, including CYSHCN

County oral health surveys were conducted in 3 counties for use in community needs assessments.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Smiles for Wisconsin Seal-A-Smile Sealant Program	X			
2. Healthy Smiles for Wisconsin Oral Health Infrastructure Support				X
3. Technical Assistance		X		
4. Oral Health Surveillance			X	

5.				
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b. Current Activities

1. Healthy Smiles for Wisconsin Seal-A-Smile Program--Direct Health Care Services--Children, including CYSHCN

In 2007/08 Maternal Child Health Block Grant funding was provided to 2 local agencies to provide oral health assessment and sealants to eligible children. It is projected that 225 children will be served.

The Department is contracting with CHAW to manage the Healthy Smiles for Wisconsin Seal-A-Smile initiative in 2007/08. There are 21 community or school-based programs as a result of the Wisconsin Seal-A-Smile program.

The department wrote and received additional funding through a HRSA funded Workforce grant, at just over $95,000.

2. Healthy Smiles for Wisconsin Oral Health Infrastructure Support--Infrastructure Building Services--Children, including CYSHCN

The Department is contracting with Children's Health Alliance of Wisconsin (CHAW), the Title V grantee for statewide child health system building, to manage Health Smiles for Wisconsin: Seal-A-Smile initiative.

3. Technical Assistance--Enabling Services--Children, including CYSHCN

Technical Assistance is being provided to 21 state-funded sealant programs in cooperation with CHAW Oral Health Project Manager.

4. Oral Health Surveillance--Population-Based Services--Children, including CYSHCN

The Department is currently conducting the "Make Your Smile Count" Oral Health Survey of third grade students.

c. Plan for the Coming Year

1. Healthy Smiles for Wisconsin Seal-A-Smile Program--Direct Health Care Services--Children, including CYSHCN.

In 2009 the Department anticipates continued funding to at least 20 community and school-based programs through the GPR and HRSA funded Seal-A-Smile project. The Department will contract with CHAW, the Title V grantee for statewide child health system building, to manage Healthy Smiles for Wisconsin: Seal-A-Smile initiative in 2008/09. There are currently 21 school-based or community sealant projects.

The Department will be working with CHAW on the goals and objectives of the HRSA funded "Wisconsin Community-Based System of Oral Health for Children with Special Health Care Needs" specifically targeting school based opportunities to reach CYSHCN.

2. Healthy Smiles for Wisconsin Oral Health Infrastructure Support--Infrastructure Building Services--Children, including CYSHCN

The Department will contract with CHAW, the title V grantee for statewide child health system building, will be actively involved in improving dental access and care through the Healthy Smiles for Wisconsin: Seal-A-Smile initiative in 2008/09. CHAW will conduct regional grantee for Seal-A-Smile grantees. The purpose of these meetings is to streamline information and review best practices.

In 2009 the Department intends to continue to support the MCH sealant program template and will advocate to local agencies for their participation.

3. Technical Assistance--Enabling Services--Children, including CYSHCN

Technical assistance will be provided to approximately 21 state-funded dental sealant programs in cooperation with CHAW Oral Health Program Manager. The State Oral Health Consultant will monitor contracts to manage the CDC Oral Disease Prevention Grant in School-Aged Children and the Healthy Smiles for Wisconsin Seal-A-Smile grants.

Data on the number of children provided protective sealants and with untreated decay in primary and permanent teeth will be available through this program in June 2008.

The State Public Health Dental Hygienist and the Chief Dental Officer will continue to play an active role in the Wisconsin Oral Health Coalition. The coalition will consider policy development changes to facilitate improved access to preventive programs.

4. Oral Health Surveillance--Population-Based Services--Children, including CYSHCN

The Department will publish and disseminate data collected through the Make Your Smile Count Survey of third grade students. The data will be used to evaluate current programs and as a framework for the development of new preventive based programs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	3.3	3.2	3.2	3.1	2.8
Annual Indicator	3.6	2.5	2.8	1.8	1.8
Numerator	39	27	30	19	19
Denominator	1094410	1073202	1062378	1078955	1078955
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	2.8	2.7	2.7	2.6	2.5

Notes - 2007

Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Data issues: Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Injury Mortality Module, accessed 04/08/2008.

Notes - 2005
Data issues: Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Injury Mortality Module, accessed 05/11/2007.

a. Last Year's Accomplishments
1. Car Seat Safety Education and Fitting/Inspections--Enabling Services--Infants and children

In 2007, 33 LHDs conducted checks for proper installation and use of car seat restraints through the MCH performance-based contracts, and conducted over 3,800 CPS screenings using this funding. Of those screened, 82% of the children were not properly positioned in a seat prior to instruction. This was the most frequently selected objective by LHDs.

2. Community Education and Outreach--Population-Based Services--Infants and children

Education to support the proper use of child passenger safety seats continued in 2007. Staff from DPH provided technical assistance to LHDs for implementation and sustainability of CPS programs.

3. Enhancement and Expansion of Partnerships--Infrastructure Building Services--Infants and children

LHDs continue to utilize partnerships with DOT law enforcement agencies, local hospitals, EMS, and SAFE KIDS to support their efforts to provide education and services pertaining to child passenger safety. Money is also available from DOT for staff training and education and for purchasing car seats for low income families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Car Seat Safety Education and Fitting/Inspections		X		
2. Community Education and Outreach			X	
3. Enhancement and Expansion of Partnerships				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1. Car Seat Safety Education and Fitting/Inspections--Enabling Services--Infants and children

In 2008, 37 LHDs are conducting checks for proper installation and use of car seat restraints through the MCH performance-based contracts. This is the most commonly selected objective, with $334,184 in Title V dollars going toward this effort in Wisconsin. We are currently evaluating this objective to assure that it meets the needs of both LHDs and the MCH program.

2. Community Education and Outreach--Population-Based Services--Infants and children

Education to support the proper use of child passenger safety seats continues in 2008. The number of LHDs who selected this objective increased by 5 between 2007 and 2008. We strongly encourage partnership with local organizations, such as SAFE KIDS, hospitals, and fire departments, to support this activity and reduce duplication of efforts. LHDs have reported that successful local coalitions formed around CPS efforts have allowed them to take on other injury-related activities in their community.

3. Enhancement and Expansion of Partnerships--Infrastructure Building Services--Infants and children

LHDs continue to utilize partnerships with DOT law enforcement agencies, local hospitals, EMS, and SAFE KIDS to support their efforts to provide education and services pertaining to child passenger safety. Money is also available from DOT for staff training and education and for purchasing car seats for low income families.

c. Plan for the Coming Year

1. Car Seat Safety Education and Fitting/Inspections--Enabling Services--Infants and children

It is anticipated that LHDs and others will continue to provide child passenger and car seat safety outreach, seats, training, and education to families with young children. We hope to increase the number of LHDs that select child passenger safety template objectives through the performance-based contracting system. Based on the review completed in 2008, we will make necessary changes to enhance this objective from the perspective of the LHD and the MCH program.

2. Community Education and Outreach--Population-Based Services--Infants and children

We will continue to collaborate with DOT, which has been able to provide funding for safety seats for low income families in the past, and other state and local agencies to promote and provide outreach activities and public education. We will support LHDs in forming partnerships with local entities, and provide technical assistance in development of local programs.

3. Enhancement and Expansion of Partnerships--Infrastructure Building Services--Infants and children

As opportunities are identified, new partnerships will be developed and/or current ones strengthened to accomplish the work of the new projects and initiatives.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				40	25
Annual Indicator			25.0	26.0	26.6
Numerator			2810	3309	3622
Denominator			11238	12726	13616

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	26	27	28	30	32

Notes - 2007
Source: 2007 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2006
Source: According to PedNSS 2006, 77% Hispanic infants were ever breastfed compared to 63.9% white infants, 47.2% African American, 62.1% American Indian/Alaskan Native, 43.8% Asian/Pacific Islander and 59.4% multiple races; for breastfed at least 6 months, 35.1% Hispanic infants were breastfed, compared to 20.9% white infants, 10.3% African American, 18.9% American Indian/Alaskan Native, 14.4% Asian/Pacific Islander and 12.6% multiple races.
Data issue: The data for 2005 cannot be amended in the TVIS; the data entered for 2005 are incorrect and should be 2,519/10,409 = 24.2%. Source: 2005 Pediatric Nutrition Surveillance System report (PedNSS); received from CDC in mid-January 07.
The subsequent years' objectives were revised to reflect 2004 and 2005 data that indicated about 25% of mothers breastfed their infants at 6 months of age. The HP 2010 objective is 50%; however, given current data and program knowledge, we feel that our objectives do not reflect current breastfeeding practices and have revised them downward.

Notes - 2005
Source: 2004 Pregnancy Nutrition Surveillance System report.
Data issue: Data for 2005 are not available from the Pediatric Nutrition Surveillance System until 2007. Our objectives reflect the Wisconsin Nutrition and Physical Acticity State Plan's 2007 objective that 50% of mothers will breastfeed their infants at 6 months of age; Healthiest Wisconsin 2010's Adequate and Appropriate Nutrition priority also has this same objective.

a. Last Year's Accomplishments
Impact on National Outcome Measures: The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both infant and mother as well as benefits to the community as a whole.

1. Breastfeeding Education, Promotion and Support--Enabling Services--Pregnant and breastfeeding women

About 30% of the LHDs receive Title V funds through performance-based contracting for perinatal care coordination services, including breastfeeding promotion and support to achieve increased initiation and duration rates. LHDs also selected an objective of breastfeeding initiation and duration for more than one month outside the parameters of prenatal case management services. Breastfeeding education, promotion and support are included in the care for pregnant women and mothers and infants.

2. Breastfeeding Peer Counseling and Breast Pump Distribution--Enabling Services--Pregnant and breastfeeding women

The State WIC Breastfeeding Coordinator manages the Breastfeeding Peer Counseling Program (BFPCP) and the WIC Breast Pump Program. In CY 2007, the WIC Program trained 18 new breastfeeding peer counselors who provided prenatal breastfeeding counseling and postpartum

support in 26 local WIC projects statewide. Breastfeeding peer counseling improves initiation and duration rates of breastfeeding. In the initial run of the WIC Breastfeeding Reports, the State average 6 month breastfeeding duration rate was 24.2% compared to the BFPCP 6 month duration rate of 26.2%. The WIC Breast Pump Program provides breast pumps to WIC mothers that are not eligible for Medical Assistance.

The Title V funded agencies continue to coordinate breastfeeding activities with the WIC Program for pregnant women, mothers and infants. This includes referrals for care from WIC to the MCH program and from MCH to WIC.

3. Wisconsin Partnership for Activity & Nutrition--Population-Based Services--Pregnant and the general public

The WIC Breastfeeding Coordinator co-chaired the breastfeeding committee of the Wisconsin Partnership for Activity & Nutrition (WI PAN). A key obesity prevention focus area of WI PAN is the promotion and support of breastfeeding. The Breastfeeding Coordinator provided numerous presentations including conferences attended by Family Resource Centers, Head Start/Early Head Start, hospitals, Birth to Three, Even Start Family Literacy Schools, Early Childhood Centers, and County and Tribal Social Service Departments.

The WIC Breastfeeding Coordinator updated the Wisconsin Breastfeeding Resource Directory which assists the public and health care professionals in locating appropriate referral sources for breastfeeding mothers who need help.

4. Collaboration and Partnerships - Local Breastfeeding Coalitions--Infrastructure Building--Pregnant and breastfeeding women

The WIC Breastfeeding Coordinator sent out Governor's Proclamations, Action Ideas and Resources for Health Professionals for World Breastfeeding Week/Month to the 24 local breastfeeding coalitions in Wisconsin. The Wisconsin WIC Program and Milwaukee County Breastfeeding Coalition provided a three day training for community partners in the Milwaukee area, including breastfeeding peer counselors, hospitals and clinics, teen parenting programs, public health programs, La Leche League, breastfeeding coalitions and others.

The WIC Breastfeeding Coordinator presided as the proctor and network coordinator for the CDC bimonthly State Breastfeeding Coalition conference calls in 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Breastfeeding Education, Promotion and Support		X		
2. Breastfeeding Peer Counseling and Breast Pump Distribution		X		
3. Wisconsin Partnership for Activity & Nutrition			X	
4. Collaboration and Partnerships - Local Breastfeeding Coalitions				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Breastfeeding Education, Promotion and Support--Enabling Services--Pregnant and breastfeeding women

The 10 Steps to Breastfeeding Friendly Health Departments assists LHDs in their efforts to protect, promote and support breastfeeding. This objective was the 4th most selected objective negotiated through performance based contracting.

2. Breastfeeding Peer Counseling and Breast Pump Distribution--Enabling Services--Pregnant and breastfeeding women

In CY 2008, the WIC Program trained 18 new peer counselors who provide prenatal breastfeeding counseling and postpartum support in 32 local projects. In the most recent WIC Breastfeeding report, the State average 6 month breastfeeding duration rate was 25.6% compared to the 6 month duration rate of 27.7% for those in the Peer Counseling Program.

3. Wisconsin Partnership for Activity & Nutrition--Population-Based Services--Pregnant and breastfeeding women

The Breastfeeding Committee of WI PAN is developing a module that will be used by breastfeeding coalitions and public health professionals to train childcare staff.

4. Collaboration and Partnerships - Local Breastfeeding Coalitions--Infrastructure Building Services--Pregnant and breastfeeding women

The Breastfeeding Committee of WI PAN will develop a survey to assess the needs of local breastfeeding coalitions in Wisconsin.

c. Plan for the Coming Year

1. Breastfeeding Education, Promotion and Support--Enabling Services--Pregnant and breastfeeding women

In CY 2009, the 10 Steps to Breastfeeding Friendly Health Departments objective will continue to be promoted to LHDs in their efforts to protect, promote and support breastfeeding. Self-assessment tools and LHD reports that describe strategies and activities implemented by the health department that are required in the 10 Steps will be reviewed. LHDs that have completed required activities of all 10 Steps will be awarded "Breastfeeding Friendly" status.

2. Breastfeeding Peer Counseling and Breast Pump Distribution--Enabling Services--Pregnant and breastfeeding women

In CY 2009, the State WIC Breastfeeding Coordinator will continue to manage the Breastfeeding Peer Counseling Program (BFPCP) and the WIC Breast Pump Program. In addition to the 3 day Loving Support Training for the new peer counselors, continuing education programs will be provided for experienced peer counselors.

3. Wisconsin Partnership for Activity & Nutrition--Population-Based Services--Pregnant and breastfeeding women

The WIC Breastfeeding Coordinator will continue to co-chair the breastfeeding committee of the Wisconsin Partnership for Activity & Nutrition (WI PAN). The Breastfeeding Committee will promote and distribute the "How to Support a Breastfeeding Mother -- A Guide for the Childcare Center" to breastfeeding coalitions and public health professionals to train childcare staff.

4. Collaboration and Partnerships - Local Breastfeeding Coalitions--Infrastructure Building Activities--Pregnant and breastfeeding women

The Breastfeeding Committee of WI PAN will distribute and evaluate the survey developed in 2008 for the local breastfeeding coalitions. This survey will assess specific breastfeeding coalition needs, best means to address needs and optimal approaches for networking.

The WIC Breastfeeding Coordinator will continue to preside as the proctor and network coordinator for the CDC bimonthly State Breastfeeding Coalition conference calls in 2009.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	93	94	95	95	95
Annual Indicator	94.5	94.5	95.6	94.5	97.2
Numerator	64921	65528	65780	66675	69364
Denominator	68688	69308	68785	70519	71389
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	97.5	97.5	97.8	97.8	98

Notes - 2007
Hearing screening data are reported on the newborn blood-spot card that is sent from the birth hospital to the Wisconsin State Lab of Hygiene (WSLH). The data are electronically messaged daily to the Wisconsin Early Hearing Detection and Intervention Tracking Referral and Coordination (WE-TRAC) system. Unlike the data reported in previous years from WSLH records, the 2007 data are generated directly from the WE-TRAC system. This method has helped resolve accuracy issues involving duplicate records and delayed records that occurred in the past. The data adhere to the CDC reporting standards for EHDI statistics; i.e., the screened number excludes newborns who were missed in one or both ears, refused screening, or died before screening was possible.

Notes - 2006
Data on hearing screening are reported on one page of the newborn blood-spot card that goes to the Wisconsin State Lab of Hygiene (WSLH). The data are delivered as a space-delimited file at least once a month, converted to a SAS dataset, and used to compile monthly reports on hearing screening in Wisconsin. The hearing screening records are also sent directly to the Wisconsin Early Hearing Detection and Intervention Tracking Referral and Coordination (WE-TRAC) System.
Data issues: Hearing screening results are occasionally separated from the blood card, delaying accurate reporting. Alternatively, sometimes the blood screening is repeated, but not the hearing screening, therefore, there may be duplicate (inaccurate) reporting. In 2006 functionality was added to WE-TRAC to allow administrators to remove duplicate records from the WE-TRAC data set. Currently, we are developing reports that will allow us to take data from WE-TRAC rather than from the blood card file. This will allow for more accurate data, and will also allow us to include data on delayed inpatient screenings done for special care infants, and report on other "accounted for" babies, or babies that have a valid reason for not being screened. With these

new reports and the rapid increase of hospitals reporting using WE-TRAC, we anticipate being able to use WE-TRAC data for future reporting.

Notes - 2005
Data on hearing screening are reported on one page of the newborn blood-spot card that goes to the Wisconsin State Lab of Hygiene (WSLH). The data are delivered as a space-delimited file at least once a month, converted to a SAS dataset, and used to compile monthly reports on hearing screening in Wisconsin. The hearing screening records are also sent directly to the Wisconsin Early Hearing Detection and Intervention Tracking Referral and Coordination (WE-TRAC) System.
Data issues: Hearing screening results are occasionally separated from the blood card, delaying accurate reporting. Alternatively, sometimes the blood screening is repeated, but not the hearing screening, therefore, there may be duplicate (inaccurate) reporting. In 2005, the processing logic used to handle SLH records was changed to greatly reduce the occurance of duplicate cases. In 2006, functionality was added to WE-TRAC to handle any remaining duplicate records. Also, a phased release system began in 2007. Data will be collected directly from facilities using WE-TRAC, which will place accurate testing and follow-up responsibility on the birth hospitals, lessening the possibility that hearing screening results (and follow-up services) will be lost or delayed.

a. Last Year's Accomplishments
1. Outreach/Public Education--Enabling Services--Pregnant women, mothers, and infants

Wisconsin Sound Beginnings made available print outreach materials related to early hearing detection and intervention (EHDI) such as "A Sound Beginning for Babies" and "Babies and Hearing Loss" series to providers and produced a captioned version of the EHDI Video in Spanish, English and Hmong. WSB sent out just in time packets of information to pediatric primary care providers and collaborated with the Wisconsin Educational Services Program for the Deaf and Hard of Hearing (WESP DHH) to produce a just in time packet for early intervention providers.

2. WSB/Congenital Disorders Program--Population-Based Services--Pregnant women, mothers, and infants

WSB Continued to coordinate follow-up activities with the WSLH and worked to improve data quality through the targeted monitoring of hospital faxed data updates.

3. Support Services for Parents--Enabling Services--Pregnant women, mothers, and infants

The Sixth Annual Statewide Parent Conference focused on Looking Ahead to a Bright Future. In attendance were 101 families with ten Spanish speaking families and one Hmong family. A pre-conference for professionals who work with d/hh kids drew 76 people.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach/Public Education		X		
2. WSB/Congenital Disorders Program			X	
3. Support Services for Parents		X		
4. Birth-3 Technical Assistance Network				X
5. EHDI Workgroup				X
6. Reduce Lost to Follow-up				X
7.				
8.				

9.				
10.				

b. Current Activities

1. Outreach/Public Education--Enabling Services--Pregnant women, mothers, and infants

WSB is disseminating the EHDI Video to community partners and collaborating with the WESP DHH Program to disseminate the newly created just in time packet for early intervention providers for newly diagnosed children.

2. WSB/Congenital Disorders Program--Population-Based Services--Pregnant women, mothers, and infants

WSB continues to coordinate follow-up with the WSLH and works to improve data quality. We are working to eliminate delayed submission of hearing results on the blood card via a new feature in WE-TRAC and investigating the collection of risk factors for late onset hearing loss.

3. Support Services for Parents--Enabling Services--Pregnant women, mothers, and infant

The 7th Annual Statewide Parent Conference and professional pre-conference is being planned.

4. Birth-3 Technical Assistance Network--Infrastructure Building Services--CYSHCN

We are investigating linking WE-TRAC to the new web-based Birth to 3 system. Also looking to determine current numbers of children with hearing loss receiving early intervention services.

5. EHDI Workgroup--Infrastructure Building Services--CYSHCN

This workgroup is undergoing a conversion to focus on quality improvement efforts and will be called the EHDI Quality Improvement Consortium.

6. Reduce Lost to Follow-up--Infrastructure Building--CYSHCN

Continue to develop and implement Guide By Your Side Follow-through Program and WE-TRAC reports.

c. Plan for the Coming Year

1. Outreach/Public Education--Enabling Services-Pregnant women, mothers, and infants

WSB will continue to market existing materials and will work to revise the Babies and Hearing Loss Notebook for Families. WSB will continue to collaborate with the WESP DHH Program to evaluate and improve just in time packets for early intervention providers when we receive notification of a newly diagnosed child.

2. WSB/Congenital Disorders Program--Population-Based Services--Pregnant women, mothers, and infants

WSB will continue to coordinate follow-up with the WSLH and work to improve data quality. Delayed or missing hearing screening results will be submitted through WE-TRAC. WSLH will begin collection of risk factors for late onset hearing loss on the newborn screening card. We will investigate inputting hearing screening results for clients without blood screen.

3. Support Services for Parents--Enabling Services--Pregnant women, mothers, and infants

An Annual Statewide Parent Conference and professional pre-conference will be held and will

focus on parent professional teamwork.

4. Birth-3 Technical Assistance Network--Infrastructure Building Services--CYSHCN

Babies identified as deaf or hard of hearing will be connected to Birth-3 via WE-TRAC and reports will be automatically generated to determine the current numbers of children with hearing loss referred to early intervention services.

5. EHDI Workgroup--Infrastructure Building Services--CYSHCN

The EHDI Quality Improvement Consortium will be convened.

6. Reduce Lost to Follow-up--Infrastructure Building Services--CYSHCN

A series of learning collaboratives that focus on the reduction of lost to follow-up will be conducted. A EHDI web-based toolkit will be designed as a resource to the learning collaboratives. The Guide By Your Side Follow-through Program and WE-TRAC system will continue to be developed, enhanced, and implemented.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	3	2.9	2	2	2.8
Annual Indicator	2.0	2.2	2.9	3.8	3.8
Numerator	26000	28000	38100	48000	48000
Denominator	1300000	1300000	1300000	1273000	1273000
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	2.7	2.6	2.5	2.5	2.5

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Family Health Survey, 2006. Madison, Wisconsin: 2008.
Numerator: Weighted data. Denominator: Weighted data.
Data issues: 1)Estimated numbers have been rounded to the nearest 1,000. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance coverage, and use of health care services among Wisconsin residents. The survey has questions about health-related limitations and chronic conditions for persons greater than age seventeen.

Notes - 2005
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Family Health Survey, 2005. Madison, Wisconsin: 2007.
Numerator: Weighted data. Denominator: Weighted data.
Data issues: 1)Estimated numbers have been rounded to the nearest 1,000. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance coverage, and use of health care services among Wisconsin residents. The survey has questions about health-related limitations and chronic conditions for persons greater than age seventeen. 2) Indicator: 2005 data indicate a slight increase in the percentage of children without health insurance in Wisconsin. 3) We have revised our objectives to reflect issues of survey methodology and the implications of enrollment in Medicaid and SCHIP (BadgerCare and BadgerCare Plus).

a. Last Year's Accomplishments
1. Medicaid Outreach Overview--Enabling Services--Children, including CYSHCN

Title V MCH Program staff monitored enrollment trends in Wisconsin Medicaid and in BadgerCare Plus, the Wisconsin CHIP Program. The combined number of persons eligible for BadgerCare and Family Medicaid increased 5% from 540,662 in 2006 to 574,341 in 2007; though the percent of children in the state without health insurance increased from 2.9% to 3.8%. This likely reflects the implementation by Medicaid of the need to have verification of citizenship and income. The MCH program supported Medicaid outreach activities for children at risk served by the CYSHCN Regional Centers in five locations throughout Wisconsin.

2. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

Legislation to implement BadgerCare Plus was passed in September 2007 in the SFY 07-09 budget and the program began enrolling families on February 1, 2008. Increasing numbers of families eligible to enroll will impact the Medicaid enrollment numbers. In January 2008, the WI Medicaid program awarded a total of $447,142 to 32 community-based organizations to reach out to Wisconsin families and enroll children in BadgerCare Plus starting February 1, 2008. These community partners will share information about the program's benefits and provide direct, confidential application assistance. In some cases, children will be able to receive immediate, express enrollment in BadgerCare Plus through these community partners.

3. "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

The "Covering Kids" Program in Wisconsin (CKF-WI) is housed at the UW-Madison School of Human Ecology, working in partnership with UW-Extension and other partners throughout the state. It is a coalition of more than 65 organizations committed to reducing the number of uninsured children and families. CKF-WI was active throughout 2007 with funds from DHCF and both Medical Schools of Wisconsin. CKF-WI is making sure those who are eligible for BadgerCare Plus know about and can easily enroll in the programs for which they qualify.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medicaid Outreach Overview		X		
2. Governor's BadgerCare Plus Initiative		X		
3. "Covering Kids" Program		X		
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Medicaid Outreach Overview--Enabling Services--Children, including CYSHCN

Title V, MCH program continues the activities of recent years in this area.

2. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

The Title V MCH/CYSHCN Program continues to provide assistance to Governor Doyle's expansion to the Wisconsin BadgerCare Plus Program that provides health insurance for all children in the state. The MCH program will have an opportunity to outreach to pregnant women, mothers, infants, children, and children and youth with special health care needs and their families to improve access to health care coverage and connect to community programs enrolling families.

3. Support the "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

In cooperation with UW-Extension, the Title V MCH/CYSHCN Program continues to provide support for state and local coalitions, funded through 2010. These activities will assist children and their families and build access to funding mechanisms through BadgerCare Plus for affordable, comprehensive health care coverage.

c. Plan for the Coming Year

1. Medicaid Outreach Overview--Enabling Services--Children, including CYSHCN

The Title V MCH/CYSHCN Program will maintain the activities of recent years in this area.

2. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

The Title V MCH/CYSHCN Program will continue to provide assistance to Governor Doyle's expansion to the Wisconsin BadgerCare Program that is to provide an opportunity for health insurance for all children in the state and improve access to health care coverage.

3. Support the "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

In cooperation with UW-Extension, the Title V MCH/CYSHCN Program will continue to provide support for state and local coalitions that are funded through 2010. These activities will assist children and their families and build access to funding mechanisms through BadgerCare Plus for affordable, comprehensive health care coverage.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				12.1	29
Annual Indicator			13.3	29.3	29.2
Numerator			6893	15137	15078
Denominator			51825	51667	51636
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	28	27	26	25	24

Notes - 2007
Source: 2007 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2006
Source: 2006 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention. The subsequent years's objectives were revised to reflect the correct data for 2005 and program knowledge about this population.

Notes - 2005
Data issues: Data for 2005 are not available from the Pediatric Nutrition Surveillance System until 2007.

a. Last Year's Accomplishments
1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through performance based contracting (PBC), 21 LHDs worked to create environments that promote healthy eating, physical activity, and a healthy weight. The activities are linked to Healthiest Wisconsin 2010, the Nutrition and Physical Activity State Plan and local community health improvement plans. Many provided educational programs and opportunities in a variety of settings including: child care, worksite, schools, and community. One LHD sponsored a health promotion class for 70 students. Another distributed "Just Keep Moving" brochures to highlight opportunities for physical activity in the community. One tribal health department sponsored a "Team Up to Defeat Diabetes" conference for enrolled families, a "Heart Healthy" event where families learned about portion control, blood sugars, blood pressure, and tobacco cessation, and another event to help families think about hidden sugars and calories in beverages.

2. Community Campaigns--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Through the PBC system, LHDs promoted nutrition and physical activity in their community through campaigns. These included a Fun Walk/Run with 72 participants, a Choosing Low-fat Milk Campaign, Safe Routes to School, Turn off TV Week, and community walking programs. One community fitness challenge with 41 groups participating identified that 50% of the participants self-reported an increase in physical activity as a result of the campaign.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Through PBC, LHDs improved the nutrition and physical activity environment in their communities. Strategies implemented included community planning, walkability/bikeability surveys, fruit and vegetable audits, FIT WIC assessments, Safe Routes to School, starting school breakfast programs in 13 schools, school staff wellness, school wellness policies, community assessments, worksite wellness, breastfeeding support at work, work with farmers' markets to increase participation, and childcare curriculum. One LHD worked with several schools to improve their nutrition and physical activity environments. Some of the changes included: a summer nutrition education program, development of a nature trail with a Vita course for students, staff and parents, development of a walking program for students and parents, development of a Safer Routes to School Program and walking program for students with theme walks. Another LHD worked with the Milwaukee Public School and 50% (104 schools) completed a nutrition and physical activity school assessment and action plan.

4. Nutrition and Physical Activity Coalitions - Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Partnerships are vital to preventing and managing overweight. There are 47 local coalitions who focused efforts on obesity prevention in 2007.

Key partnerships that were developed by the LHDs included: the nutrition and physical activity coalitions, schools, worksites, local hospitals, farmers and farmers' market managers, UW-Extension, Master Gardeners and Preservers, economic development corporation, WIC, childcare centers, city planner, faith-based organizations, parent groups, YMCA, and minority organizations.

In many examples the work funded by MCH and through the above partnerships has been able to leverage addition grant funds, in-kind services and support.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increased Knowledge of Healthy Behaviors		X		
2. Community Campaigns			X	
3. Needs Assessments and Plans				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through performance based contracting (PBC), 29 LHDs are creating environments that promote breastfeeding, healthy eating, physical activity, and a healthy weight in all sectors. The activities are linked to Healthiest Wisconsin 2010 and the Nutrition and Physical Activity State Plan.

2. Community Campaigns--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Through the PBC system, LHDs are promoting nutrition and physical activity in their community.

These include a Fun Walk/Run, Safe Routes to School, Turn off TV Week and WE CAN.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Through PBC, LHDs are improving the nutrition and physical activity environment and building the infrastructure. Strategies include: walkability surveys, childcare environment assessments, Safe Routes to School, school wellness, community assessments, worksite wellness, work with farmers' markets, and childcare curriculum.

4. Nutrition and Physical Activity Coalitions - Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Partnerships are vital to preventing obesity. There are 48 local coalitions who currently focus on nutrition, physical activity and obesity prevention.

c. Plan for the Coming Year

1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through the performance based contracting system, LHD will be encouraged to choose a template objective that provides focused effort related to obesity prevention through increased breastfeeding, increased fruit and vegetable consumption, increased physical activity, decreased television time, decreased sugar-sweetened beverage consumption and decreased consumption of high energy dense foods. These activities will be linked to the Healthiest Wisconsin 2010 and the Wisconsin Nutrition and Physical Activity State Plan to prevent obesity and related chronic diseases.

2. Community Campaigns--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Community-wide campaigns (such as Safe Routes to School, TV Turn Off Week, Governor's Challenge) may be planned as part of the work of LHDs, coalitions, and community-based organizations to implement the Wisconsin Nutrition and Physical Activity State Plan. Community-wide campaigns are implemented in conjunction with other strategies (such as policy change, environmental change or education) to increase the impact of the campaign.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

The Wisconsin Partnership for Activity and Nutrition (WI PAN) and the Nutrition and Physical Activity Program plans to develop resources to assist LHDs, coalitions, and community-based organizations to implement evidence-based strategies to prevent overweight and obesity, work with schools to apply for the Governor's School Health Award, implement a childcare intervention, and promote the Worksite Kit and Safe Routes to School. The Program and WI PAN will continue to promote the use of the State Plan as a "blueprint" for activities to prevent and manage overweight among children and their families.

4. Nutrition and Physical Activity Coalitions - Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

State and community partnerships are vital to preventing and managing childhood overweight. There are ~48 local coalitions who will focus on preventing overweight, improving nutrition and increasing physical activity. The coalitions focus on a variety of issues related to childhood overweight including family meals, being active as a family, safe neighborhoods, access to

healthy food as well as food security and hunger. An annual survey will be conducted to capture current capacity to implement interventions, identify training and resource needs and highlight successes.

Key partners include: the WIC Program, MCH Programs, DPI programs (Team Nutrition), the Child and Adult Care Feeding Program, Dept. of Transportation, Dept. of Agriculture, UW-Extension, Minority Health Program, LHDs, and community coalitions.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				14.5	14
Annual Indicator			14.0	14.9	14.9
Numerator			9812	10715	10715
Denominator			70012	72114	72114
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	13.5	13	12.5	12	12

Notes - 2007
Data issue: 2007 data will not be available from the Bureau of Health Information and Policy until 2009. Furthermore, the Bureau of Health Information and Policy most likely will not have data for this indicator until 2010 after the revised birth certificate is implemented with a new on-line system (projected to be in place by 2009). Wisconsin was awarded the Pregnancy Risk Assessment Monitoring System (PRAMS) in April, 2006. We do not expect to have data from PRAMS until late 2008 or early 2009.

Notes - 2006
Source: The data for 2005 are wrong; they should be: 9,503/70,719 = 13.4%; the 2005 data were entered as provisional data for the 2007 application. There were 70,934 births in Wisconsin in 2005. Birth certificate data indicate that 61,216 reported they did not smoke during pregnancy; 9,503 reported smoking, and there were 215 missing. Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish, Birth Counts Module, accessed 02/22/2007.
Data issues: The data for this indicator are not available in Wisconsin. Therefore, we are using data for SPM #7, the percent of women who use tobacco during pregancy. 2006 data will not be available from the Bureau of Health Information and Policy until 2008. Furthermore, the Bureau of Health Information and Policy most likely will not have data for this indicator until 2010 after the revised birth certificate is implemented with a new on-line system projected to be in place by 2009. Wisconsin was awarded the Pregnancy Risk Assessment Monitoring System (PRAMS) in April, 2006. We do not expect to have data from PRAMS until 2008-2009.

Notes - 2005

Source: There were 70,131 births in Wisconsin in 2004. Birth certificate data indicate that 60,200 reported they did not smoke during pregnancy; 9,812 reported smoking, and there were 119 missing. Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish, Birth Counts Module, accessed 04/05/2006.
Data issues: These data are from 2004 and for SPM #7, the percent of women who use tobacco during pregnancy. 2005 data will not be available from the Bureau of Health Information and Policy until 2007. Furthermore, the Bureau of Health Information and Policy most likely will not have data for this indicator until 2010 after the revised birth certificate is implemented with a new on-line system projected to be in place by 2009. Wisconsin was awarded the Pregnancy Risk Assessment Monitoring System (PRAMS) in April, 2006. We do not expect to have data from PRAMS until 2010.

a. Last Year's Accomplishments
Relates to Priority Need #7--Smoking and Tobacco Use. In 2006, birth certificate data indicated 14.9% of Wisconsin women smoked during pregnancy, a slight increase from 2005 when 13.4% indicated they smoked during pregnancy (the most recent data for the U.S. for 2005 for the 36 unrevised [1989 birth certificate] reporting areas was 10.7%).

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

The Title V Program funded 31 LHDs totaling 35 objectives addressing a variety of perinatal-related issues.

As reported for 2007 in SPHERE, of those women who received a prenatal assessment utilizing both Title V funds and Medicaid PNCC, 48% reported smoking before pregnancy, 31% reported smoking during pregnancy, and 19% reported decreasing smoking during pregnancy. Other SPHERE data show of the women whose smoking changed during pregnancy and were followed, 78% reported maintenance of non smoking status and 35% reported exposure to secondhand smoke.

2. First Breath--Enabling Services--Pregnant women, mothers, and infants

The Title V Program continued its First Breath Prenatal Smoking Cessation Program partnership with the Wisconsin Women's Health Foundation (WWHF). In 2007, 1,513 women were enrolled. Preliminary analysis of quit outcomes indicates the abstinence rate remained at 36% with 1,394 women having quit smoking since the program's inception. At a Medicaid cost savings of $1,274 per quitter, this represents a $1,775,956 cost savings to the health care system.

3. Women and Tobacco Team (WATT)--Enabling Services--Pregnant women, mothers, infants

The focus of this group is on tobacco use and cessation among women of reproductive age. The group designed a 31-question survey on tobacco use practices among clinicians of women of reproductive age, specifically to Wisconsin family planning providers, advanced practice nurses with an OB/GYN specialty and licensed OB/GYNS. 215 of 746 surveys were returned (30% response rate). Key findings from the survey indicate that while many clinicians ask about tobacco use, advise women to quit, and assess their willingness to quit, few clinicians assist with the quit attempt or actively arrange follow-up support, including referrals to the Wisconsin Tobacco Quit Line. While many clinicians feel it is their role to help patients quit tobacco use, confidence in their ability to be effective is lacking. Just over half of clinicians indicated they received tobacco cessation training -- even fewer received training specific to women. Additionally, patients are infrequently advised on the dangers of secondhand smoke -- only a third of clinicians felt they were knowledgeable about secondhand smoke and its effects. The detailed report, titled "Report on Wisconsin Survey of Clinicians on Tobacco Use Practices for Women of Reproductive Age," is completed and accessible at www.wwhf.org.

4. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants

Through the Medicaid PNCC program and the MCH-funded perinatal care coordination program women who are high risk for adverse pregnancy outcomes are receiving comprehensive, strength based individual care in the prenatal period and postpartum. One of the many focuses of care is tobacco use and cessation. Once identified the participants of the program are referred to the First Breath Program, for individual, strength based assistance with decreasing tobacco use. In SFY 2007, 582 women were reported as having made a change in tobacco use during the prenatal and postpartum period and 76% of women served by these programs reported not smoking in the postpartum period.

5. Preconception Service--Enabling Services--Pregnant women, mothers, infants

Both the Infant Death Center of Wisconsin (IDC) and WAPC had preconception initiatives with a smoking cessation focus. IDC distributed culturally sensitive brochures on preconception, and a preconception curriculum and power point presentation were developed for middle school students. WAPC developed preconception tool kits for clinical practitioners.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V Funded Perinatal Services		X		
2. First Breath		X		
3. Women and Tobacco Team (WATT)		X		
4. Prenatal Care Coordination (PNCC)		X		
5. Preconception Service		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

The Title V Program funded 38 LHDs totaling 43 objectives addressing a variety of perinatal-related issues.

2. First Breath--Enabling Services--Pregnant women, mothers, infants

For CY 2008, 102 First Breath sites are participating in the program and 324 women have been enrolled.

3. Women and Tobacco Team (WATT)--Enabling Services--Pregnant women, mothers, infants

WATT continues to look for opportunities to share the survey results through local and state partnerships.

4. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants

PNCC continues to include smoking cessation services to prenatal and postpartum women.

5. Preconception Services--Enabling Services--Pregnant women, mothers, infants

IDC continues to facilitate a safe sleep/smoking cessation workgroup for a coalition of representatives from Milwaukee hospitals. WAPC has a preconception committee working on a survey for healthcare providers about preconception practices including smoking cessation and has released the preconception tool kit for use in clinics.

c. Plan for the Coming Year

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

Due to the complex nature of smoking during pregnancy, this topic will continue to be a priority for the Title V Program. Title V funds will continue to be provided to the local level that encourage and support agencies to incorporate and provide services and counseling to women who use tobacco during pregnancy.

2. First Breath--Enabling Services--Pregnant women, mothers, infants

The Title V Program will continue as a partner to accomplish the goals of the First Breath Program. This partnership will focus on the following needs: invigorate and motivate participating clinicians; compete with other health care needs for limited clinician time; address clinical challenges (i.e. the risk for post-delivery relapse, unsupportive significant others, willingness to cut down but not quit, untruthful self-report, and failure to implement the agreed-to quit plan); and identify sustainable funding. First Breath will also work to increase enrollment within existing sites, expand to reach incarcerated women and continue expansion efforts in Southeastern Wisconsin.

3. Women and Tobacco Team (WATT)--Enabling Services--Pregnant women, mothers, infants

The work of this team will continue, to include utilizing the results of the survey for clinicians on the smoking practices for women of reproductive age to determine what the priority areas are for provider continuing education and to determine other strategies to address the needs of clinicians.

4. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants

The Medicaid PNCC program will continue to support individual comprehensive strength based services, to women during the prenatal and postpartum period. Education sessions for the Great Beginnings Start Before Birth curriculum will continue to be provided by region throughout the state. Strategies will be developed and implemented through regional PNCC provider groups and SPHERE user groups, and Regional Forums to promote data collection to identify key outcomes. Strategies will be developed through regional Healthy Baby Action Teams to identify and reduce disparities.

5. Preconception Services--Enabling Services--Pregnant women, mothers, infants

The Infant Death Center of Wisconsin will continue to disseminate preconception/interconception brochures that focus on women's health, including smoking cessation. The safe sleep/smoking cessation workgroup will continue to work with the community on education for creating smoke free environments. The WAPC Preconception Committee will develop an education plan for clinical providers on preconception health that includes a smoking cessation focus.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	7	7	9	9.2	9
Annual Indicator	11.2	9.5	11.0	8.4	8.4
Numerator	46	39	45	34	34
Denominator	409420	409811	409101	404777	404777
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	8.7	8.6	8.5	8.5	8.5

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Mortality Module, accessed 04/10/2008.

Notes - 2005
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Mortality Module, accessed 04/10/2007.

a. Last Year's Accomplishments
1. Anticipatory Guidance, Risk Assessment and Referrals--Direct Health Care Services--Adolescents

LHDs, in collaboration with others such as local human and social services, identified and implemented evidence-based risk assessments of depression for youth and made the appropriate referrals. Education and training was provided to communities, targeting both professionals and the general public. Mental Health America of Wisconsin (MHA), in collaboration with the Suicide Prevention Initiative (SPI) partners, continued its work with primary care providers, schools, and community groups to develop local coalitions, heighten awareness, provide education, ensure procedures and policies are in place in schools for prevention, intervention, and postvention of suicides. MHA successfully rolled out the Garrett Lee Smith grants as the state's designee to local communities. Two LHDs conducted community-based activities to address depression, mental illness, and suicide prevention in their communities, as reported in the MCH data system, SPHERE. Across the state, LHDs provided health teaching to 396 clients on depression, 39 clients on mental health primary prevention, and 10 clients on suicide. 326 clients were screened for depression, and 92 clients were referred for mental health services.

2. Training and Presentations to Raise Awareness and Reduce Stigma--Population-Based Services--Adolescents

SPI partners and others continue to provide training, presentations, workshops, and displays.

3. Suicide Prevention Initiative--Infrastructure Building Services--Adolescents

The expanded Suicide Prevention Initiative (SPI) functioned as the Steering Committee for the newly received SAMHSA Garrett Lee Smith grant. Ongoing support and technical guidance was provided to local coalitions and groups coming together to explore ways to prevent suicide and/or contagion within their communities through SPI membership attending local community meetings, providing trainings, materials, resources, and/or leadership.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Anticipatory Guidance, Risk Assessment and Referrals	X			
2. Training and Presentations to Raise Awareness and Reduce Stigma			X	
3. Suicide Prevention Initiative (SPI)				X
4. Data				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Anticipatory Guidance, Risk Assessment and Referrals--Direct Health Care Services--Adolescents

The MCH staff, along with the SPI group and other partners around the state, work to provide support and technical assistance to LHDs, communities, and other organizations that have taken on suicide prevention as one of their priorities. Kenosha County HD successfully wrote a grant application and received funding to support a three-year project to improve risk assessment, referrals, and access to direct care for those at risk for suicide.

2. Training and Presentations to Raise Awareness and Reduce Stigma--Population-Based Services--Adolescents

SPI partners and others continue to provide training, presentations, workshops, and displays at conferences and events. Key efforts include work with the Garrett Lee Smith grantees (who target youth in their projects).

3. Suicide Prevention Initiative (SPI)--Infrastructure Building Services--Adolescents

The SPI group continues to meet on a bimonthly basis and provides guidance to MHA, who administers the Garrett Lee Smith grants around the state as the state's designee. Working with CHAW developing local child death review teams (CDRTs).

4. Data--Infrastructure Building Services--Adolescents

A statewide report, The Burden of Suicide in Wisconsin, will be released in late summer 2008. This document provides information on deaths due to suicide, suicide attempts, demographic and circumstance information, and the cost to our state

c. Plan for the Coming Year

1. Anticipatory Guidance, Risk Assessment, and Referrals--Direct Health Care Services--Adolescents

Work with community and professional groups to provide prevention, assessments, referrals and intervention will continue. We will keep template objectives on suicide prevention in the performance-based contracting and encourage communities to select these objectives to either develop their suicide prevention coalition or enhance their current coalition. Kenosha County will continue to implement their 3 year grant to increase risk assessment in schools, provide a referral system and direct services to their community. We will support them in any way possible.

2. Training and Presentations--Population-Based Services--Adolescents

Membership of SPI will continue to provide training and presentations locally and statewide to promote and enhance awareness, reduce stigma, develop coalitions, procedures, policies, programs and activities to prevent suicide across the lifespan. Training will also occur on the data and use of the report on the burden of suicide.

3. Suicide Prevention Initiative (SPI)--Infrastructure Building Services--Adolescents

SPI will continue to work with the Garrett Lee Smith grantees to build infrastructure within their communities as well as promote the development of other community coalitions and groups and support those who already have programs and activities in place.

4. Data--Infrastructure Building Services--Adolescents

We will continue to provide data and analysis assistance to LHDs and other community organizations. Analysis of WVDRS data will continue on at least a quarterly basis and subsequently disseminated to better understand the burden of suicide in Wisconsin. Working with local CDRTs to use National MCH CDR data system.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	74.5	75	81	81.5	82
Annual Indicator	80.2	77.4	80.6	74.8	74.8
Numerator	698	655	712	667	667
Denominator	870	846	883	892	892
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	82.5	83	83	83	83

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy.
Data issue: In Wisconsin, hospitals self-designate level of care. Wisconsin does not have a regulatory function to stanrdize these self-designations. 95% confidence intervals are: 77.6%, 72.0%.

Notes - 2005
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy.
Data issue: In Wisconsin, hospitals self-designate level of care. Wisconsin does not have a regulatory function to stanrdize these self-designations. 95% confidence intervals are: 83.2%, 78.0%.

a. Last Year's Accomplishments
Impact on National Outcome Measures: NPM#17 relates to National Outcome Measures #1 Infant mortality rate and #3 Neonatal mortality rate. Hospitals in Wisconsin self designate level of perinatal care. Wisconsin does not have regulatory function over the designations.

1. WAPC Efforts on Regionalization of Perinatal Care--Infrastructure Building Services--Pregnant women, mothers, infants

The Wisconsin Association for Perinatal Care facilitated activities to support the use of levels of perinatal care adopted from the American Academy of Pediatrics definition of levels of neonatal care: Level I provides well newborn care for infants and stabilizing care for infants of 35-37 weeks gestation and beyond; IIA provides care for preterm or ill infants requiring stabilization efforts and are either expected to recover rapidly or are awaiting transfer to another facility; IIB provides care at IIA level plus mechanical ventilation for brief durations or continuous positive airway pressure; IIIA provides comprehensive care for infants born >28 weeks and weighing >1,000 g, able to provide life support and mechanical ventilation in addition to minor surgical procedures; IIIB provides comprehensive care for the extremely low birth weight infant (28 weeks, 1,000 g) with advanced respiratory support, full range of pediatric subspecialists, advanced imaging, and surgical abilities; IIIC provides comprehensive care for premature infants at the IIIB level in addition to being able to provide ECMO and complex surgeries. WAPC contacted all birth hospitals and 2 NICU hospitals that do not perform births, to provide education on the self assessment tool located on the WAPC website, www.perinatalweb.org. In addition, WAPC provided distance-based Q&A sessions on the levels of care self-assessment initiative for assessment coordinators.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WAPC Efforts on Regionalization of Perinatal Care				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. WAPC Efforts on Regionalization of Perinatal Care--Infrastructure Building Services--Pregnant women, mothers, infants

The Wisconsin Association for Perinatal Care is continuing to provide education to hospitals on the self-assessment tool and materials about the levels of perinatal care. WAPC is reviewing the first set of completed self-assessments submitted.

c. Plan for the Coming Year

1. WAPC Efforts on regionalization of Perinatal Care--Infrastructure Building Services--Pregnant women, mothers, infants

WAPC will obtain information about the levels of care that birth hospitals provide that mirror the levels proposed by the AAP, and make this available on the WAPC web site. WAPC will continue to promote the use of PeriData.Net, a web-based perinatal database, for quality improvement in birth hospitals, and plans to develop a module for newborn/NICU care.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	84.7	85	85.5	86	86.5
Annual Indicator	84.7	85.1	85.0	83.8	83.8
Numerator	59296	59666	60309	60610	60610
Denominator	69999	70131	70934	72301	72301
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	87	87.5	88	88	88

Notes - 2007

Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 04/29/2008.

Notes - 2005

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 04/11/2007.

a. Last Year's Accomplishments

Impact on National Outcome Measures: NPM #18 relates to National Outcome Measures #1 Infant mortality rate, #2 Disparity between Black and White IMR, #3 Neonatal mortality rate, and

#5 Perinatal mortality rate. The overall proportion of women who received prenatal care in the first trimester was 84% in 2006, the same as in 1996. The proportion with first trimester care increased for mothers aged less than 15, 18-19, 20-24, and 40 and older; and in all race/ethnicity groups except whites.

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

The Title V program funded 845 women served through objectives addressing prenatal care. As reported in SPHERE and MCH end of year reports, 59% of women initiated prenatal care in the first trimester.

2. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants

The Great Beginnings Start Before Birth curriculum was provided to enhance PNCC psychosocial support services. Data collection in SPHERE was encouraged for monitoring key outcomes. The Womens Health Now and Beyond Pregnancy project was piloted regionally, to enhance PNCC postpartum services to include a focus on preconception/interconception services before future pregnancies. Empowering Families in Milwaukee served 179 women prenatally providing comprehensive services and supporting early prenatal care.

3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women, mothers, infants

The Title V Program has collaborated with The Black Health Coalition's Milwaukee Healthy Beginnings Project (MHBP) on the Milwaukee FIMR project. The project director of the MHBP has facilitated the Service Provider Meetings for the state's initiative to Eliminate Racial and Ethnic Disparities in Birth Outcomes. The Honoring Our Children Project with Great Lakes Inter-Tribal Council reports 70% (217/311) of prenatal women received first trimester prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Title V Funded Perinatal Services		X		
2. Prenatal Care Coordination (PNCC)		X		
3. Federal Healthy Start Projects in Wisconsin			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

The Title V MCH/CYSCHN Program is funding 35 objectives at local health departments to address prenatal issues.

2. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants

Training sessions for PNCC and reproductive health were provided for the local health departments Through regional PNCC provider groups and SPHERE user group meetings, data collection and monitoring of key outcomes is promoted. The Womens Health Now and Beyond

Pregnancy pilot project has been implemented with services that include assuring women have emergency contraception and dual protection, with a plan for primary birth control on hand before delivery; along with promotion of the use of multivitamins with folic acid and women's health. Empowering Families in Milwaukee is in the 3rd year of providing comprehensive home visiting services and during the 2008 expects that 75% of new mothers will be enrolled in the program for services early in pregnancy.

3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women, mothers, infants

Title V MCH/CYSHCN staff serve on advisory committees for the Healthy Start projects and participate in collaborative efforts related to FIMR. PNCC and Reproductive Health training well be provided for Tribal sites.

c. Plan for the Coming Year

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

The Title V MCH/CYSHCN Program will continue to support early entry into prenatal care by funding individual perinatal care coordination services and perinatal system-building activities at the local level.

2. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants

Regional training sessions for Great Beginnings Start Before Birth curriculum will be provided. Use of data to monitor key outcomes will be promoted at regional PNCC provider group meetings and SPHERE user group meetings. The Women's Health Now and Beyond Pregnancy pilot project will be expanded statewide, providing preconception/interconception services to women, and promoting women's health with multivitamins with folic acid. An MCH conference is being planned to provide education on the lifecourse perspective of health and it's relationship to birth outcomes. Contractual responsibility for EFM will transfer to the Department of Children and Families (DCF) beginning July 1, 2008. The Title V, MCH Program will continue to collaborate with the City of Milwaukee Health Department in cooperation with the DCF to assure continuing quality in programs and services to pregnant women and infants. Plans continue with an evaluation of the Empowering Families in Milwaukee program under the direction of the staff in the DHFS, Office of Policy Initiatives & Budget, Policy & Research Section with an interim report expected March 2009.

3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women, mothers infants

Title V MCH/CYSHCN staff will continue to serve on advisory committees for the Healthy Start projects and participate in collaborative efforts related to the Milwaukee and Racine FIMR programs. Annual PNCC trainings are planned with Great Lakes Inter-Tribal Council and the tribal sites. The Great Beginnings Start Before Birth curriculum will be presented at the next educational session.

D. State Performance Measures

State Performance Measure 1: *Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				24.4	24
Annual Indicator		17.3	22.7	22.2	21.1
Numerator		55515	64059	62935	59799
Denominator		320422	282070	282970	282970
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	26	28.1	29	30	31

Notes - 2007
Source: 2007 enrollment data from Wisconsin Department of Health and Family Services, Division of Health Care Financing, Medicaid program data.
Data issue: These data represent a point in time and the number of women enrolled in the FPW as of 12/31/2007; therefore, the data are subject to fluctuations and there was a slight decrease in 2007 compared to 2006.

Notes - 2006
Source: 2006 enrollment data from Wisconsin Department of Health and Family Services, Division of Health Care Financing, Medicaid program data.
Data issue: These data represent a point in time and how many women were enrolled in the FPW as of 12/31/2006; therefore the data are subject to fluctuations and there was a slight decrease in 2006 compared to 2005.

Notes - 2005
Data source: 2005 enrollment data from Wisconsin Department of Health and Family Services, Division of Health Care Financing, Medicaid program data.

a. Last Year's Accomplishments
1. Outreach and Enrollment--Enabling Services--Women of reproductive age

2007 was the last year of Wisconsin's five year Medicaid Family Planning Waiver. Wisconsin family planning providers implemented national Medicaid Deficit Reduction Act (DRA) requirements to provide applicant documentation of identity and citizenship. These requirements suppressed enrollment due to the increased administrative complexities of enrollment. There was no indication that decreased enrollment was the result of ineligible applicants.

2. Milwaukee Adolescent Pregnancy Prevention Partnership--Enabling Services--Adolescents

The Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP) was established, through a competitive grant application process, to provide Medicaid Family Planning Waiver (FPW) outreach to and increased enrollment opportunities for sexually-active youth in Milwaukee who are at high risk of unintended pregnancy. The partnership involves coordination of outreach and reproductive health services among key community-based service organizations, which are positioned to reach and serve this population segment.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach and Enrollment		X		
2. Milwaukee Adolescent Pregnancy Prevention Partnership		X		
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Outreach and Enrollment--Enabling Services--Women of reproductive age

2008 is the first year of a 3-year renewal for Wisconsin's Family Planning Medicaid Waiver. Additional administrative requirements could further suppress enrollment. Real-time income verification requirements will require income documentation for the period 30 days prior to FPW application. This further increases the administrative complexity for enrollment. Increased outreach and enrollment activities have begun in Milwaukee which has approximately 15% of estimated statewide need.

2. Milwaukee Adolescent Pregnancy Prevention Partnership--Enabling Services--Adolescents

The MAPPP partnership of community-based organizations is focusing on the development and adoption of evidence-based, focus-group tested messages. These include messages for Medicaid FPW outreach and services, as well as for contraceptive services and supplies including emergency contraception in advance of actual need and dual protection to prevent unintended pregnancy and reduce the risk of sexually transmitted disease. A youth advisory group is used to improve the effectiveness of these messages.

c. Plan for the Coming Year

1. Outreach and Enrollment--Enabling Services--Women of reproductive age

2009 will be the second year of a 3-year renewal for Wisconsin's Family Planning Medicaid Waiver. Increased outreach will continue in Milwaukee. Continuing education and training will continue to increase outreach in the rest of Wisconsin's 72 counties, and to streamline the enrollment process at family planning clinics.

2. Milwaukee Adolescent Pregnancy Prevention Partnership--Enabling Services--Adolescents

The MAPPP initiative will focus on increased outreach (to increase actual Medicaid FPW enrollment): an increased level of outreach and community education with consistent messaging. Outreach will also be targeted to youth already enrolled in traditional Medicaid, emphasizing their right to obtain family planning services outside their assigned HMO, through any medical provider of their choice. Increased quality assurance for compliance with the emergency contraception and dual protection standards of care will be parallel priorities to assure quality reproductive health through Medicaid-supported services.

State Performance Measure 2: *Percent of Medicaid and BadgerCare recipients, ages 3-20, who received any dental service during the reporting year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				30.4	30.8
Annual Indicator		30.2	30.2	25.8	22.4
Numerator		72012	72012	51414	90164
Denominator		238459	238459	199164	403190
Is the Data Provisional or Final?				Final	Final

	2008	2009	2010	2011	2012
Annual Performance Objective	31	31.2	31.4	30	30

Notes - 2007
Data issue: These data are for the State Fiscal Year. The overall percentage of 22.4% in 2007 is slighly lower compared to 2006 and is statistically significant. We will monitor this performance measure for trend in subsequent years.

Notes - 2006
Data issue: These data are for the State Fiscal Year. The overall percentage of 25.8% in 2006 is slighly lower compared to 2005 and is statistically significant. We will monitor this performance measure for trend in subsequent years.

Notes - 2005
Data issue: Data for 2005 are not available from the Division of Health Care Financing until 2007.

a. Last Year's Accomplishments
1. Dental Sealant Program--Population-Based Services--Children--including CYSHCN

In 2006/08 21 community or school-based programs hosted 174 Seal-A-Smile (SAS) events. SAS screened 8,522 children, delivered sealants to 5,602 children. The program documented that 374 children with special health care needs were served. In addition to placing 15,287 sealants on permanent first molars, 6,724 children received topical fluoride treatments, 12,076 children received oral health education and 3,671 were referred for additional dental care. The SAS program average for sealant placement cost per child is $21.92, however the cost per cavity averted, according to the Center for Disease Control and Prevention health economists is $51.48. Nine of the 17 State GPR-funded dental access grantees provided direct service in school-based settings including Head Start, providing a wide range of preventive, and in some cases restorative treatment.

2. Maternal and Early Childhood Health--Population-Based Services--Pregnant women, mothers, infants

In 2006/07 310 primary care providers were trained in fluoride varnish placement, program protocols and implementation.

3. Clinical Services and Technical Assistance--Population-Based Services--Pregnant women, mothers, infants and children, including CYSHCN

State GPR funds 2 rural dental health clinics for services to low income families, including pregnant women, mothers, infants and children, including CYSHCN. CESA 11 services were provided in Turtle Lake, Menomonie, Chippewa Falls and Hayward four days per week with over 3,300 new patient visits in 2006/07. Marshfield Family Health Center has fixed sites in Ladysmith, Owen, and Chippewa Falls. During 2006/07, 8,141 total Medicaid patients (identified by payor type) were treated with 44% between the age of 3-20 years. The State Public Health Dental Hygienist monitors these grants.

4. Oral Health Surveillance--Infrastructure Building Services--Children including CYSHCN

In 2006/07 3 county oral health surveys were conducted, establishing baseline data.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Dental Sealant Program			X	

2. Maternal and Early Childhood Oral Health			X	
3. Clinical Services and Technical Assistance			X	
4. Oral Health Surveillance				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Dental Sealant Program--Population-Based Services--Children, including CYSHCN

In 2007-08 there are 21 community or school-based programs as a result of the Wisconsin Seal-A-Smile program.

2. Maternal and Early Childhood Health--Population-Based Services--Pregnant women, mothers, infants

In 2007-08 over 325 primary care providers are being trained by Regional Oral Health Consultants and the State Public Health Dental Hygienist to integrate preventive oral health measures into healthcare practice.

3. Clinical Services and Technical Assistance--Population-Based Services--Pregnant women, mothers, infants, and children, including CYSHCN

State GPR funding supports comprehensive oral health care to underserved populations at the various clinics at Marquette University's School of Dentistry, two WI Technical Colleges, and two rural dental health clinics.

Providing technical assistance and oversight to Children's Health Alliance of Wisconsin, monitoring grant performance on HRSA funded Wisconsin Community-based System of Oral Health for Children and Youth with Special Health Care Needs.

4. Oral Health Surveillance--Infrastructure Building Services--Children including CYSHCN

A statewide "Make Your Smile Count" oral health survey of third grade students will be conducted with an additional baseline evaluative component of body mass index. Approximately 115 schools and 5,500 children will participate.

c. Plan for the Coming Year

1. Dental Sealant Program--Population-Based Services--Children, including CYSHCN

In 2009 we anticipate continued funding to at least 20 community and school-based progams through the GPR and HRSA funded Seal-A-Smile project.

2. Maternal and Early Childhood Health--Population-Based Services--Pregnant women, mothers, infants

The State Public Health Dental Hygienist will provide training to primary care providers to intergrate oral health measures into healthcare practice.

3. Clinical Services and Technical Assistance--Population -Based Services--Pregnant women, mothers, infants and children, including CYSHCN

State GPR will continue to fund two rural dental health clinics to provide preventive and restorative care to low income families. The Marshfield clinic in Chippewa Falls will be providing full range services to the developmentally disabled. In addition GPR will continue funding Marquette University access projects and two WI Technical Colleges for increased care to underserved populations.

Continue providing technical assistance to the 16 state funded dental access grantees. The target population for these grantees include pregnant women, infants, children, and CYSHCN.

Provide technical assistance as a primary collaborative partner to the Children's Health Alliance of Wisconsin on the HRSA funded Wisconsin Community-based System of Oral Health for Children and Youth with Special Health Care Needs.

State GPR will continue to fund15 fluoride supplement projects and 17 school-based fluoride mouthrinse programs.

4. Oral Health Surveillance--Infrastructure Building Services--Children including CYSHCN

During the 2008-09 school year will prepare and conduct the second statewide "Healthy Smiles for a Healthy Head Start" oral health survey of Head Start/Early Head Start children.

State Performance Measure 3: *Percent of children, ages 6 months-5 years, who have age-appropriate social and emotional developmental levels.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				24	83.2
Annual Indicator			22.2	82.9	94.3
Numerator			1084	131	1103
Denominator			4876	158	1170
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	94.2	94.2	94.3	94.3	94.4

Notes - 2007
In mid-2006, SPHERE changed to a new reporting method for collection of the ASQ:SE results, therefore, results were under reported in 2006. The 2007 increase in numbers of ASQ: SE screening results reflects improved reporting of results, as well as increased interest by LHDs in providing this screening program for young children.

Notes - 2006
Data was transferred from SPHERE to new ASQ:SE screens but not all data came over as separate from the developmental screens. Thus data for 2006 of ASQ:SE screenings completed and results are under reported. SPHERE correction will collect sound data during 2007 and with more screening programs occurring throughout the state, more ASQ:SE screenings will be completed. It is expected that numbers reflecting age-appropriate social-emotional development of children ages 6 months to 5 years in the state will increase and better reflect progress in Wisconsin. The MCH program will monitor this situation and review the data indicating achievement for SPM#4.

Notes - 2005
Data Source: 2005 data from the Secure Public Health Electronic Reporting Environment (SPHERE). During 2005, data entry limitations did not allow an ability to distinguish child's

developmental scores from social-emotional scores nor if the result of the testing was reported at age appropriate levels. About 22% of all clients, ages 6 months to 5 years, (or 1,084 of 4,876), received developmental assessments in 2005. This situation was corrected during the 2006 reporting period.

a. Last Year's Accomplishments
The performance measure relates to Wisconsin's Priority Need -- Mental Health and Mental Disorders, and is identified in Healthiest Wisconsin 2010, the state's public health plan.

1. Social-emotional screening of young children--Direct Health Care Services--Children, including CYSHCN

Home visiting programs to prevent child maltreatment include periodic screening of social emotional development using the Ages and Stages Questionnaire: Social Emotional. Also 11 counties and one tribe used MCH block grant funds to screen children using the ASQ: SE. Referral for additional assessment occurs if needed. All MCH-funded programs report results of developmental assessments in the SPHERE data system. For 2007, 1,170 (or 3%) of all children age 6 months through age 5 years who received MCH program services were reported as having an ASQ: SE screen. Of those receiving an ASQ: SE screen, 94% were reported at age appropriate social/emotional developmental levels. Sixty children who were identified with concerns were reported as receiving some type of services for the concern and an additional 9 were enrolled in early intervention.

2. Education and training--Enabling Services--Children, including CYSHCN

The ASQ and ASQ: SE tools have been shown to have acceptable validity and reliability rates for use with diverse populations of families with young children. Under the leadership of the University of Wisconsin-Extension, a one day training program was held 5 times during 2007, once in each of the DPH regions to assure use of the tools as intended. In 2007, 400 persons were trained at the 5 UW-Extension sponsored trainings. In partnership with MCH, 4 training sessions were held in 2007 by staff from WI-Alliance for Infant Mental Health (WI-AIMH) to increase capacity to foster healthy child development. Total attendance at all sessions was 75 and 95.4% of attendees reported after completing the training that they would be using the materials in their programs to support parent's skills in promoting child development.

3. Medical Home Initiative--Enabling Services--CYSHCN

A Medical Home conference was held November 15, 2007 for primary practice physicians and their staff to encourage and foster continued spread of medical home. Workshops promoted the use of developmental screening in primary practice settings including social emotional development using the ASQ: SE.

4. Wisconsin Initiative for Infant Mental Health (WIIMH)--Infrastructure Building Services--Children, including CYSHCN

The MCH Program Advisory Committee continued to focus work in 2007 on three mental health interest areas. One of the three foci is infant and young child mental health. An Action Guide was developed as part of this work and will enable the MCH Program to identify the work of other partners and possibly track initiatives of those partners who are doing work in the area of Infant Mental Health.

5. Early Childhood Comprehensive Systems Plan--Infrastructure Building Services--Children, including CYSHCN

The Wisconsin ECCS plan began implementation activities in September 2006 and continues under the leadership of WI-AIMH. Many key state partners, including staff of the state MCH

program, have contributed to the work to improve systems of services for young children including fostering healthy social-emotional development. A key focus area within this plan is health consultation for early care and education. During 2007, local infant mental health coalitions in Marathon and Rock counties piloted Infant Mental Health consultation services to staff of child care centers to improve child social emotional competence.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Social-emotional screening of young children	X			
2. Education and Training		X		
3. Wisconsin Initiative for Infant Mental Health				X
4. Early Childhood Comprehensive Systems Plan				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Social-emotional screening of young children--Direct Health Care Services--Children, including CYSHCN

During 2008, social emotional screenings at 11 DPH/MCH home visiting programs will be transferred on July 1, 2008 to the new DCF for ongoing management. Also, 11 LHDs and 1 tribe are using MCH funds for ASQ: SE screening programs.

2. Education and training--Enabling Services--Children, including CYSHCN

During 2008, under the leadership of the UW-Extension, seven all day ASQ and ASQ: SE tool training sessions will be held. A training program specifically to meet needs of public health staff is being piloted by staff of the Northern CYSHCN Regional Center.

3. Wisconsin Initiative for Infant Mental Health--Infrastructure Building Services--Children, including CYSHCN

In January 2008, WIIMH become part of Children's Service Society of Wisconsin under the umbrella of Children's Hospital of Milwaukee and is now known as the Wisconsin Alliance for Infant Mental Health (WI-AIHM). WI-AIMH continues to support the work of state and local organizations in their programs for infants, young children, and their families.

4. Early Childhood Comprehensive Systems Plan--Infrastructure Building Services--Children, including CYSHCN

Implementation of WI ECCS plan continues using a holistic approach to building systems that support a statewide network of child services in key ECCS areas. A grant reapplication will be submitted for the new grant cycle beginning 9/1/08.

c. Plan for the Coming Year

1. Social-emotional screening of young children--Direct Health Care Services--Children, including CYSHCN

The state Title V MCH program will continue to support social emotional screenings in LHD programs using MCH funds. MCH will continue to advocate for the use of the ASQ: SE tool to screen young children in the state for social-emotional competence.

2. Education and training--Enabling Services--Children, including CYSHCN

In cooperation with UW-Extension and other public health programs, the Title V MCH Program will continue in 2009 to ensure training is available to assure intended use of the ASQ and ASQ: SE tools are occurring. However due to retirement of UW-Extension training staff, only two ASQ and ASQ:SE trainings will be scheduled for home visiting staff during 2009.

3. Wisconsin Initiative for Infant Mental Health--Infrastructure Building Services--Children, including CYSHCN

The Infant and Mental Health DHFS Leadership Team workgroup continues to meet and collaborate to promote the efforts that advance infant mental health, promote knowledge and practice, and provide training to assure best practice. A subset of this workgroup will address the policy, billing, and training issues to allow providers to bill and obtain reimbursement for infant mental health interventions. This leadership team has produced the document entitled The 2007 Annual Report and Fact Sheet for the Dept. Infant Mental Health Leadership Team, which supports the Governor Doyle's Kid First agenda.

4. Early Childhood Comprehensive Systems Plan--Infrastructure Building Services--Children, including CYSHCN

Wisconsin will reapply for an ECCS grant to support implementation activities beyond August 31, 2008. Work will continue under the Wisconsin Early Childhood Collaborating Partners (WECCP) toward implementation of strategies to improve systems of services for young children including fostering healthy social-emotional development. Strong leadership in this partnership is provided by the Director of Wisconsin Alliance for Infant Mental Health and is coordinated with MCH program activities for young children and their families.

State Performance Measure 4: *Rate per 1,000 of substantiated reports of child maltreatment to Wisconsin children, ages 0 - 17, during the year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				6	6
Annual Indicator	5.7	6.1	6.0	5.5	5.5
Numerator	7994	8600	8148	7485	7485
Denominator	1402633	1413635	1360112	1357139	1357139
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	6	6	6	6	6

Notes - 2007
Data issue: Data for 2007 are not available from the Division of Children and Family Services until 2009.
Source: Wisconsin Deparatment of Health and Family Services, Division of Children and Family Services, Office of Program Evaluation and Planning, Wisconin Child Abuse and Neglect Report, 2006 Data.

Notes - 2006

Source: Wisconsin Deparatment of Health and Family Services, Division of Children and Family Services, Office of Program Evaluation and Planning, Wisconin Child Abuse and Neglect Report, 2006 Data.

Notes - 2005
Source: Wisconsin Deparatment of Health and Family Services, Division of Children and Family Services, Office of Program Evaluation, Wisconin Child Abuse and Neglect Report, 2005.

a. Last Year's Accomplishments
The performance measure relates to Wisconsin's Priority Need -- Intentional and Unintentional Injuries and Violence, and is identified in Healthiest Wisconsin 2010, the state's public health plan.

1. Family Foundations Home Visiting--Enabling Services--Infants and Young Children to age three years and their families

Home visiting programs for Prevention of Child Abuse and Neglect known as Family Foundations, funded by general purpose revenue under Wisconsin 1997 Act 293, continued in its 9th year providing comprehensive home visiting program services at 10 sites in the state. During 2007, 356 families received home visiting services. An additional 172 families determined at-risk for child maltreatment received informal planning and purchase of services to address needs causing concerns for child well-being. The home visiting program was transferred to the newly created Department of Children and Families with the passage of Governor Doyle's 07-09 budget.

2. Milwaukee Comprehensive Home Visiting, Empowering Families of Milwaukee--Enabling Services--Pregnant women, Infants and Young Children to age five years and their families

Empowering Families of Milwaukee home visiting program operation continued through 2007 under the leadership of the City of Milwaukee Health Department. Program manager position was vacant from August 2007 and filled in December. Contracts were implemented with five community-based organizations to provide home visiting services to work with public health nurses. An initial program evaluation 18-month report was released by DHFS evaluators that described program implementation. During 2007, 593 women were referred, and 226 (38%) were pregnant and 367 (62%) were parenting. The home visiting program was administratively transferred to the newly created Department of Children and Families with the passage of Governor Doyle's 07-09 budget.

3. Milwaukee County Home Visiting Training Program--Enabling Services--Pregnant women, infants, and Young Children and their families

Throughout 2007 a training contract with UW-Extension was in place to enhance skills and abilities for staff working in programs in Milwaukee County providing services to families of young children. Significant support was offered to the staff development of the Empowering Families of Milwaukee home visiting program. A total of 357 staff from 37 community-based organizations and health departments attended a variety of trainings supporting emerging and advanced skills of home visitors.

4. Prevention of Shaken Baby Syndrome--Population-Based Services--Pregnant women, infants, and Young Children and their families

During 2007, the MCH program continued activities to support messages of prevention of Shaken Baby Syndrome to new parents in programs at birthing hospitals, county departments, home visiting and prenatal/postpartum case management programs, and maternity homes.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Foundations Home Visiting		X		
2. Milwaukee Comprehensive Home Visiting - Empowering Families of Milwaukee		X		
3. Milwaukee County Home Visiting Training Program		X		
4. Prevention of Shaken Baby Syndrome			X	
5. Increase Surveilance Capabilities for Child Maltreatment				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Family Foundations Home Visiting--Enabling Services--Infants and Young Children to age 3 years and their families

Family Foundations home visiting continues at 10 sites and expansion did not occur. The program is transferred to the DCF as of July 1, 2008 and the State Title V MCH is assisting in the transition of the program.

2. Milwaukee Comprehensive Home Visiting, Empowering Families of Milwaukee--Enabling Services--Pregnant women, infants, and Young Children to age 5 years and their families

MHD with its community partners continues to provide home visiting services for at-risk families. The program is transferred to the DCF as of July 1, 2008 and the State Title V MCH is assisting in the transition of the program.

3. Milwaukee County Home Visiting Training Program--Enabling Services--Pregnant women, infants, and Young Children and their families

Training contract with UW-Extension Milwaukee Co. for programs working with families of young children continues in 2008 with a plan for sessions on smoking cessation and prevention.

4. Prevention of Shaken Baby Syndrome--Population-Based Services--Pregnant women, infants, and Young Children and their families

WI MCH program continues to maintain involvement in implementation requirements.

5. Increase surveillance capabilities for child maltreatment--Infrastructure Building Services--Pregnant women, infants, children and their families

The program continues to evaluate appropriate surveillance strategies for child maltreatment.

c. Plan for the Coming Year

1. Family Foundations Home Visiting and Empowering Families of Milwaukee--Enabling Services--Infants and Young Children and their families

These two programs will move to the new Department of Children and Families (DCF) on July 1, 2008. The MCH program will seek to coordinate activities with these programs once they are in the new department. Training for these programs will also be transferred to DCF.

2. Increase surveillance capabilities for child maltreatment--Infrastucture Building--Infants and

Young Children and their families

Staff will continue to evaluate existing surveillance systems and consider new methods of collecting or linking data with the intent of forming a surveillance system for child maltreatment or analysis protocols for use on existing datasets. This will be done to the extent possible with the prevention programs for child maltreatment housed in DCF.

State Performance Measure 5: *Percent of children who receive coordinated, ongoing comprehensive care within a medical home.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				52	52.5
Annual Indicator	51.2	51.2	51.2	52.5	52.5
Numerator	679854	679854	679854	694021	694021
Denominator	1327839	1327839	1327839	1321945	1321945
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	53	53.5	55	56	58

Notes - 2007
Data issue: These are Wisconsin-specific weighted data from the National Survey of Children's Health, National Center for Health Statisitics, Centers for Disease Control and Prevention.

Notes - 2006
Data issue: These are Wisconsin-specific weighted data from the National Survey of Children's Health, National Center for Health Statisitics, Centers for Disease Control and Prevention.

Notes - 2005
Data issue: These are Wisconsin-specific weighted data from the National Survey of Children's Health, National Center for Health Statisitics, Centers for Disease Control and Prevention.

a. Last Year's Accomplishments
1. Out-of-Home Placements--Infrastructure Building Activities--Children

The Wisconsin Medicaid program implemented BadgerCare Plus on February 1, 2008 that extends coverage to parents with children in out of home placement who are working on a reunification plan and to 18 to 21 year olds who age out of the foster care system. Additional funds to promote screening and medical home concepts for children were not funded. MCH staff continues to participate in the implementation of the ABCD Screening Academy work plan to improve Medicaid policies that promote developmental screening by the primary care provider.

2. Comprehensive Home Visiting--Enabling Services--Infants and Children

Home visiting programs statewide continued to assure access of enrolled infants to primary preventive health care services provided by a primary care physician and are required to capture data including medical home status in SPHERE. The home visiting programs were transferred to the newly created Department of Children and Families with the passage of Governor Doyle's 07-09 budget. This may impact the ability of the MCH program to continue to implement reporting of this measure by the home visiting sites. An MOU has been developed.

3. Early Childhood Comprehensive Systems--Population-Based Services--Young Children

Wisconsin Early Childhood Collaborating Partner's (WECCP) Action Team worked to implement components of the ECCS grant with the formation of the Healthy Children workgroup. A Medical Home Summit was conducted on November 15, 2007 with over 140 participants representing physicians, nurses, social workers, Birth-3, early educators, public health, administrators, parents and youth with special needs. Other participants joined by web cast for the morning plenary on Medical Home and then participated in facilitated regional meetings by teleconference. Approximately 72 early childhood professionals viewed the opening and keynote presentations of the Medical Home Summit and identified multiple ways to support families in having a medical home. Attendees were encouraged to utilize the Wisconsin Medical Home toolkit (www.wimedicalhometoolkit.aap.org) which was updated and includes information on developmental screening. In April 2007, the CYSHCN Program in collaboration with the WIAAP and WAFP conducted an e-mail survey to assess the baseline level of developmental screening occurring in primary care practices in Wisconsin and to compare this with national data. The survey was sent to 1,772 physicians with 173 respondents; 31% (54) were pediatricians and 67% (117) were family physicians. Over half of providers who responded always/almost always use clinical impression alone (without the use of a screening tool or checklist) to assess developmental status. About 20% of Wisconsin providers always or almost always use the Denver Developmental Screen as their preferred screening tool while 37% sometimes use the Denver. Among providers nearly 74% (96 of 130 responses) report never using the Ages and Stages questionnaire (ASQ); 90% (117 of 130 responses) never use the Parents Evaluation of Developmental Status (PEDS). Based on the results of the survey, it is clear that there are gaps between current clinical practice and best practices as recommended in the AAP 2006 Policy statement. Implementation strategies developed by the ECCS Planning Team include disseminating a checklist of traits of a medical home for young children to doctors and parents educating early childhood providers about the concepts of medical home and screening recommendations.

4. Early Hearing Detection and Intervention (EHDI)--Infrastructure Building Activities--Newborns

Wisconsin Sound Beginnings (WSB), the early hearing detection and intervention program, is one of eight states selected to participate in the MCHB funded National Initiative for Child Health Quality's (NICHQ) EHDI and Medical Home Learning Collaborative (LC). Two regional Learning Sessions including border state EHDI programs were held. WSB continues to recruit primary care providers to join the Chapter AAP EHDI Champion to participate in community EHDI improvement teams to improve linkages between population based screening program and the child's Medical Home. The framework established as part of Wisconsin's Congenital Disorders Program and WE-TRAC, the EHDI web-based real time data system, assisted this effort.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Comprehensive Home Visiting		X		
2. Early Childhood Comprehensive Systems				X
3. Early Hearing Detection and Intervention				X
4. Reproductive Health and Prenatal Care Coordination		X		
5. Patient-at-Risk				X
6. Oral Health				X
7. Early Screening				X
8.				
9.				
10.				

b. Current Activities

1. Comprehensive Home Visiting--Enabling Services--Infants and Children

The program transfers to the DCF as of July 1, 2008 and MCH is assisting in transition.

2. Early Childhood Comprehensive Systems--Population-Based Services--Young Children

Implementation strategies developed by the ECCS continue to consider impact on promoting Medical Home.

3. Early Hearing Detection and Intervention (EHDI)--Infrastructure Building Activities--Newborns

WSB continues its participation in the NICHQ EHDI. Lessons learned are improving linkages with Medical Home.

4. Reproductive Health and Prenatal Care Coordination--Enabling Services--Infants

PNCC providers match mothers with primary providers for prenatal care, postpartum, and inter-conception care and identify medical homes for the baby.

5. Early Screening--Infrastructure Building Activities--Infants and Children

Lessons learned from participation in the EHDI Learning Collaborative that support the role of Medical Home are shared with EHDI partners.

6. Oral Health--Infrastructure Building Activities--Children

The medical home concept is being applied to the concept of a dental home despite the lack of dental providers.

7. Patient-at-Risk--Infrastructure Building Activities--Children

A pilot of the Patient-At-Risk system is scheduled for rollout July 1, 2008. This web-based structure allows health care and EMS providers and planners to access health information and attend to medical needs of CYSHCN in an emergency situation.

c. Plan for the Coming Year

The concepts of Medical Home will be integrated into their framework as highlighted by the following activities:

1. Reproductive Health and Prenatal Care Coordination--Enabling Services--Infants

The MCH program will continue to promote PNCC as a comprehensive program for prenatal, postpartum and interconceptional care with a goal of including a focus on establishing medical homes for mothers and infants.

2. Early Screening--Infrastructure Building Activities--Infants and Children

Lessons learned from participation in the EHDI Learning Collaborative that support the role of Medical Home will be shared with EHDI partners through a series of regional forums, articles and other education materials directed to health care providers Quality Improvements (QI) steps such as both written and verbal communication of screening results to the primary care provider prior to hospital discharge, inclusion of screening results in the electronic medical record/hospital discharge summary, and scheduled follow-up prior to discharge will be integrated into the WSB Program QI documents and recently was awarded a 3-year grant by the MCHB to enhance this work. The Congenital Disorders Program will continue to promote the concepts of medical home

and care planning through its contracts with the Program's contracted diagnostic/treatment sites. In addition, Wisconsin is one of 18 states along with Puerto Rico and the District of Columbia selected by National Academy for State Health Policy (NASHP) to participate in a national consortium to improve early identification of young children with developmental problems.

3. Oral Health--Infrastructure Building Activities--Children and CYSHCN

A recent HRSA grant will assist the state oral health program with case management programs targeting CYSHCN and training using licensed dental hygienists. In addition planning continues to support dental homes for all children.

4. Patient-at-Risk--Infrastructure Building Activities--Children

The Title V, MCH Program will continue involvement with activities to implement the Patient-At-Risk new web-based system. This program will be owned and managed by a consortia of hospitals that receive MCH funding to serve CYSHCN.

5. Early Childhood Comprehensive Systems--Population-Based Services--Young Children

A continuing ECCS grant will be written to support components including screening of young children and the promotion of medical home.

State Performance Measure 6: *Percent of children less than 12 years of age who receive one physical exam a year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	79.5	80	80.5	81	81.5
Annual Indicator	72.6	75.7	83.0	77.1	77.1
Numerator	617000	618000	677000	641000	641000
Denominator	850000	816000	816000	831000	831000
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	81.5	81.5	81.5	81.5	81.5

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Family Health Survey, 2006. Madison, Wisconsin, 2008. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance status, and use of health services among Wisconsin residents.
Numerator: Weighted data. Denominator: Weighted data.

Notes - 2005
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Family Health Survey, 2005. Madison, Wisconsin, 2007. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance status, and use of health services among Wisconsin residents.
Numerator: Weighted data. Denominator: Weighted data.

Data issues: We did not revise subsequent year's objectives; the data reflect random fluctuations.

a. Last Year's Accomplishments
The performance measure relates to Wisconsin's Priority Need - Access to Primary and Preventive Health Services, and is identified in Healthiest Wisconsin 2010, the state's public health plan. Special access issues exist for those living in rural communities, seasonal and migrant workers, persons with special health care needs, the uninsured and underinsured, homeless persons and low income members of racial or cultural minority groups.

1. Comprehensive Well-Child Exams--Direct Health Care Services--Children, including CYSHCN

The annual health exam activity is a direct health care service for children under age 21, including children with special health care needs. The target groups for services funded by the Title V block grant are children who are uninsured or underinsured. MCH provided funds to 12 LHDs in 2007 for well-child exams for children under age 21 years, including those with special health care needs. As reported for 2007 contracts in SPHERE, 1,160 unduplicated clients aged 0-12 years were reported as receiving physical exams, which is about half of the number provided in previous years. In 2007 only 77.2% of children under age 12 years accessed at least one physical exam which is a decline from 83% during 2005 and 2006. A requirement to provide documentation of citizenship may have impacted access to health services.

2. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

Legislation to implement BadgerCare Plus was passed in September 2007 in the SFY 07-09 budget and the program began enrolling families on February 1, 2008. It is a new program for children under 19 year of age and their families in Wisconsin who need and want health insurance regardless of income. All children under 19 years old --at all income levels-- can enroll in BadgerCare Plus if they don't have access to health insurance.

3. "Covering Kids" Program Funded by the Robert Wood Johnson (RWJ) Foundation--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

"Covering Kids" Program, funded by WI Medicaid through 2006, continued its involvement in an advisory capacity for Medicaid outreach grants. Wisconsin Covering Kids has engaged in several key outreach activities in cooperation with several of the CYSHCN Regional Centers. Challenged during 2006 with verification of citizenship resulted in dramatic reduction in family Medicaid caseload. Overall family Medicaid enrollment declined from 541,749 in December 2005 to 540,432 in December 2006. With continued funds for Covering Kids and building coalition activities to improve outreach as BadgerCare Plus is implemented, it is expected that Medicaid enrollment will increase.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive Well-Child Exams	X			
2. Governor's BadgerCare Plus Inititative		X		
3. "Covering Kids" Program		X		
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

1. Comprehensive Well-Child Exams--Direct Health Care Services--Children, including CYSHCN

For 2008 consolidated contracts, 12 LHDs again submitted objectives to provide or assure access to primary preventive exams.

2. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

Legislation to implement BadgerCare Plus was passed in the 07-09 budget and implemented effective February 1, 2008. This should improve prospects for preventive services including health and oral exams all children in the state.

3. "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

Wisconsin "Covering Kids and Families" Program continues with funding grants from both state Medical Schools and from dollars from DHCF. Activities include support for coalitions to increase outreach for uninsured children and their families and to enroll them in state supported health insurance programs, such as BadgerCare.

c. Plan for the Coming Year

1. Comprehensive Well-Child Exams--Direct Health Care Services--Children, including CYSHCN

Title V MCH/CYSHCN Program remains committed to improving access to health care so that primary, preventive health care is available to young children. The Title V MCH/CYSHCN Program will continue to provide funds through the consolidated contract process promoting primary, preventive health care to young children who are uninsured or underinsured. Since the LHDs use these funds according to general program guidelines and to address local identified needs, the impact of MCH funds supporting a provision of primary, preventive health care will be gap filling.

2. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

The Title V MCH/CYSHCN Program will continue to provide assistance to Governor Doyle's planned expansion to the Wisconsin BadgerCare Program that is to provide an opportunity for health insurance for all children in the state. The MCH program will have an opportunity to outreach to pregnant women, mothers, infants, children, children and youth with special health care needs, and their families to improve access to health care coverage and connect to community programs enrolling families. This should increase access to primary preventive health exams.

3. Support the "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

In cooperation with UW-Extension, the Title V MCH/CYSHCN Program will continue to provide support for state and local coalitions, funded through 2010. These activities will assist children and their families to access mechanisms such as BadgerCare Plus if legislated to pay for primary preventive health exams. With continued funds for Covering Kids and building coalition activities to improve outreach as BadgerCare Plus is implemented, it is expected that Medicaid enrollment will increase.

State Performance Measure 7: *Percent of women who use tobacco during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	15.6	15.2	15	14.5	14
Annual Indicator	14.0	14.0	13.4	14.9	14.9
Numerator	9769	9812	9503	10715	10715
Denominator	69942	70012	70719	72114	72114
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	13.5	13	12.5	12	12

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Data issue: Data for 2007 are not available from the Bureau of Health Information and Policy until 2008.
Source: There were 70,302 births in Wisconsin in 2006. Birth certificate data indicate that 61,399 reported they did not smoke during pregnancy; 10,715 reported smoking, and there were 188 missing. Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish, Birth Counts Module, accessed 02/22/2008.

Notes - 2005
Source: There were 70,934 births in Wisconsin in 2005. Birth certificate data indicate that 61,216 reported they did not smoke during pregnancy; 9,503 reported smoking, and there were 215 missing. Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish, Birth Counts Module, accessed 02/22/2007.

a. Last Year's Accomplishments
Relates to Priority Need #7--Smoking and Tobacco Use. In 2006, birth certificate data indicated 14.9% of Wisconsin women smoked during pregnancy, a slight increase from 2005 when 13.4% indicated they smoked during pregnancy (the most recent data for the U.S. for 2005 for the 36 unrevised [1989 birth certificate] reporting areas was 10.7%).

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

The Title V Program funded 31 LHDs totaling 35 objectives addressing a variety of perinatal-related issues.

As reported for 2007 in SPHERE, of those women who received a prenatal assessment utilizing both Title V funds and Medicaid PNCC, 48% reported smoking before pregnancy, 31% reported smoking during pregnancy, and 19% reported decreasing smoking during pregnancy. Other SPHERE data show of the women whose smoking changed during pregnancy and were followed, 78% reported maintenance of non smoking status and 35% reported exposure to secondhand smoke.

2. First Breath--Enabling Services--Pregnant women, mothers, and infants

The Title V Program continued its First Breath Prenatal Smoking Cessation Program partnership

with the Wisconsin Women's Health Foundation (WWHF). In 2007, 1,513 women were enrolled. Preliminary analysis of quit outcomes indicates the abstinence rate remained at 36% with 1,394 women having quit smoking since the program's inception. At a Medicaid cost savings of $1,274 per quitter, this represents a $1,775,956 cost savings to the health care system.

3. Women and Tobacco Team (WATT)--Enabling Services--Pregnant women, mothers, infants

The focus of this group is on tobacco use and cessation among women of reproductive age. The group designed a 31-question survey on tobacco use practices among clinicians of women of reproductive age, specifically to Wisconsin family planning providers, advanced practice nurses with an OB/GYN specialty and licensed OB/GYNS. 215 of 746 surveys were returned (30% response rate). Key findings from the survey indicate that while many clinicians ask about tobacco use, advise women to quit, and assess their willingness to quit, few clinicians assist with the quit attempt or actively arrange follow-up support, including referrals to the Wisconsin Tobacco Quit Line. While many clinicians feel it is their role to help patients quit tobacco use, confidence in their ability to be effective is lacking. Just over half of clinicians indicated they received tobacco cessation training -- even fewer received training specific to women. Additionally, patients are infrequently advised on the dangers of secondhand smoke -- only a third of clinicians felt they were knowledgeable about secondhand smoke and its effects. The detailed report, titled "Report on Wisconsin Survey of Clinicians on Tobacco Use Practices for Women of Reproductive Age," is completed and accessible at www.wwhf.org.

4. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants

Through the Medicaid PNCC program and the MCH-funded perinatal care coordination program women who are high risk for adverse pregnancy outcomes are receiving comprehensive, strength based individual care in the prenatal period and postpartum. One of the many focuses of care is tobacco use and cessation. Once identified the participants of the program are referred to the First Breath Program, for individual, strength based assistance with decreasing tobacco use. In SFY 2007, 582 women were reported as having made a change in tobacco use during the prenatal and postpartum period and 76% of women served by these programs reported not smoking in the postpartum period.

5. Preconception Service--Enabling Services--Pregnant women, mothers, infants

Both the Infant Death Center of Wisconsin(IDC) and WAPC had preconception initiatives with a smoking cessation focus. IDC distributed culturally sensitive brochures on preconception, and a preconception curriculum and power point presentation were developed for middle school students. WAPC developed preconception tool kits for clinical pracitioners.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Title V Funded Perinatal Services		X		
2. First Breath		X		
3. Women and Tobacco Team (WATT)		X		
4. Prental Care Coordination (PNCC)		X		
5. Infant Death Center of WI/WAPC Statewide Programs to Improve Infant Health and Reduce Disparities		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

The Title V Program funded 38 LHDs totaling 43 objectives addressing a variety of perinatal-related issues.

2. First Breath--Enabling Services--Pregnant women, mothers, infants

For CY 2008, 102 First Breath sites are participating in the program and 324 women have been enrolled.

3. Women and Tobacco Team (WATT)--Enabling Services--Pregnant women, mothers, infants

WATTcontinues to look for opportunities to share the survey results through local and state partnerships.

4. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants

PNCC continues to include smoking cessation services to prenatal and postpartum women.

5. Preconception Services--Enabling Services--Pregnant women, mothers, infants

IDC continues to facilitate a safe sleep/smoking cessation workgroup for a coalition of representatives from Milwaukee hospitals. WAPC has a preconception committee working on a survey for healthcare providers about preconception practices including smoking cessation and has released the preconeption tool kit for use in clinics.

c. Plan for the Coming Year

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

Due to the complex nature of smoking during pregnancy, this topic will continue to be a priority for the Title V Program. Title V funds will continue to be provided to the local level that encourage and support agencies to incorporate and provide services and counseling to women who use tobacco during pregnancy.

2. First Breath--Enabling Services--Pregnant women, mothers, infants

The Title V Program will continue as a partner to accomplish the goals of the First Breath Program. This partnership will focus on the following needs: invigorate and motivate participating clinicians; compete with other health care needs for limited clinician time; address clinical challenges (i.e. the risk for post-delivery relapse, unsupportive significant others, willingness to cut down but not quit, untruthful self-report, and failure to implement the agreed-to quit plan); and identify sustainable funding. First Breath will also work to increase enrollment within existing sites, expand to reach incarcerated women and continue expansion efforts in Southeastern Wisconsin.

3. Women and Tobacco Team (WATT)--Enabling Services--Pregnant women, mothers, infants

The work of this team will continue, to include utilizing the results of the survey for clinicians on the smoking practices for women of reproductive age to determine what the priority areas are for provider continuing education and to determine other strategies to address the needs of clinicians.

4. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants

The Medicaid PNCC program will continue to support individual comprehensive strength based services, to women during the prenatal and postpartum period. Education sessions for the Great Beginnings Start Before Birth curriculum will continue to be provided by region throughout the state. Strategies will be developed and implemented through regional PNCC provider groups and SPHERE user groups, and Regional Forums to promote data collection to identify key outcomes. Strategies will be developed through regional Healthy Baby Action Teams to identify and reduce disparities.

5. Preconception Services--Enabling Services--Pregnant women, mothers, infants

The Infant Death Center of Wisconsin will continue to disseminate preconception/interconception brochures that focus on women's health, including smoking cessation. The safe sleep/smoking cessation workgroup will continues to work with the community on education for creating smoke free environments. The WAPC Preconception Committee will develope an education plan for clinical providers on preconception health that includes a smoking cessation focus.

State Performance Measure 8: *Percent of children, ages 2-4, who are obese or overweight at or above the 95th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	11	10.8	12	12.1	11.8
Annual Indicator	13.0	13.3	12.9	13.0	13.1
Numerator	6537	6893	6648	6717	6764
Denominator	50284	51825	51410	51667	51636
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	11.6	11.6	11.5	11.5	11.4

Notes - 2007
Source: 2007 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2006
Source: 2006 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2005
Source: 2005 Pediatric Nutrition Surveillance System (PedNSS).

a. Last Year's Accomplishments
1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through performance based contracting (PBC), 21 LHDs worked to create environments that promote healthy eating, physical activity and a healthy weight. The activities are linked to Healthiest Wisconsin 2010, the Nutrition and Physical Activity State Plan and local community health improvement plans. Many provided educational programs and opportunities in a variety of settings including: child care, worksite, schools, and community. One LHD sponsored a health promotion class for 70 students. Another distributed "Just Keep Moving" brochures to highlight opportunities for physical activity in the community. One tribal health department sponsored a "Team Up to Defeat Diabetes" conference for enrolled families, a "Heart Healthy" event where families learned about portion control, blood sugars, blood pressure and tobacco cessation and

another event to help families think about hidden sugars and calories in beverages.

2. Community Campaigns--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Through the PBC system, LHDs promoted nutrition and physical activity in their community through campaigns. These included a Fun Walk/Run with 72 participants, a Choosing Low-fat Milk Campaign, Safe Routes to School, Turn off TV Week, and community walking programs. One community fitness challenge with 41 groups participating identified that 50% of the participants self-reported an increase in physical activity as a result of the campaign.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Through PBC, LHDs improved the nutrition and physical activity environment in their communities. Strategies implemented included community planning, walkability/bikeability surveys, fruit and vegetable audits, FIT WIC assessments, Safe Routes to School, starting school breakfast programs in 13 schools, school staff wellnes, school wellness policies, community assessments, worksite wellness, breastfeeding support at work, work with farmers' markets to increase participation, and childcare curriculum. One LHD worked with several schools to improve their nutrition and physical activity environments. Some of the changes included: a summer nutrition education program, development of a nature trail with a Vita course for students, staff and parents, development of a walking program for students and parents, development of a Safer Routes to School Program, and walking program for students with theme walks. Another LHD worked with the Milwaukee Public School and 50% (104 schools) completed a nutrition and physical activity school assessment and action plan.

4. Nutrition and Physical Activity Coalitions--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Partnerships are vital to preventing and managing overweight. There are 47 local coalitions who focused efforts on obesity prevention in 2007.

Key partnerships that were developed by the LHDs included: the nutrition and physical activity coalitions, schools, worksites, local hospitals, farmers and farmers market managers, UW-Extension, Master Gardeners and Preservers, economic development corporation, WIC, childcare centers, city planner, faith-based organizations, parent groups, YMCA, and minority organizations.

In many examples the work funded by MCH and through the above partnerships has been able to leverage addition grant funds, in-kind services, and support.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase Knowledge of Healthy Behaviors		X		
2. Community Campaigns			X	
3. Needs Assessments and Plans				X
4. Nutrition and Physical Activity Coalitions			X	
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities

1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through performance based contracting (PBC), 29 LHDs are creating environments that promote breastfeeding, healthy eating, physical activity and a healthy weight in all sectors. The activities are linked to Healthiest Wisconsin 2010 and the Nutrition and Physical Activity State Plan.

2. Community Campaigns--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Through the PBC system, LHDs are promoting nutrition and physical activity in their community. These include a Fun Walk/Run, Safe Routes to School, Turn off TV Week, and WE CAN.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Through PBC, LHDs are improving the nutrition and physical activity environment and building the infrastructure. Strategies include: walkability surveys, childcare environment assessments, Safe Routes to School, school wellness, community assessments, worksite wellness, work with farmers markets, and childcare curriculum.

4. Nutrition and Physical Activity Coalitions--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Partnerships are vital to preventing obesity. There are 48 local coalitions who currently focus on nutrition, physical activity and obesity prevention.

c. Plan for the Coming Year

1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through the performance based contracting system, LHD will be encouraged to choose a template objective that provides focused effort related to obesity prevention through increased breastfeeding, increased fruit and vegetable consumption, increased physical activity, decreased television time, decreased sugar-sweetened beverage consumption and decreasd consumption of high energy dense foods. These activities will be linked to the Healthiest Wisconsin 2010 and the Wisconsin Nutrition and Physical Activity State Plan to prevent obesity and related chronic diseases.

2. Community Campaigns--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Community-wide campaigns (such as Safe Routes to School, TV Turn Off Week, Governor's Challenge) may be planned as part of the work of LHDs, coalitions, and community-based organizations to implement the Wisconsin Nutrition and Physical Activity State Plan. Community-wide campaigns are implemented in conjunction with other strategies (such as policy change, environmental change or education) to increase the impact of the campaign.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

The Wisconsin Partnership for Activity and Nutrition (WI PAN) and the Nutrition and Physical

Activity Program plans to develop resources to assist LHD, coalitions and community organizations to implement evidence-based strategies to prevent overweight and obesity, work with schools to apply for the Governor's School Health Award, implement a childcare intervention, and promote the Worksite Kit and Safe Routes to School. The Program and WI PAN will continue to promote the use of the State Plan as a "blueprint" for activities to prevent and manage overweight among children and their families.

4. Nutrition and Physical Activity Coalitions--Population-Based Services--Children over the age of 2, including CYSHCN and their families

State and community partnerships are vital to preventing and managing childhood overweight. There are ~48 local coalitions who will focus on preventing overweight, improving nutrition, and increasing physical activity. The coalitions focus on a variety of issues related to childhood overweight including family meals, being active as a family, safe neighborhoods, access to healthy food as well as food security and hunger. An annual survey will be conducted to capture current capacity to implement interventions, identify training and resource needs and highlight successes.

Key partners include: the WIC Program, MCH Programs, DPI programs (Team Nutrition), the Child and Adult Care Feeding Program, Department of Transportation, Department of Agriculture, UW-Extension, Minority Health Program, local health departments, and community coalitions.

State Performance Measure 9: *Ratio of the black infant mortality rate to the white infant mortality rate.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	2.5	2.4	2.4	3.7	2.9
Annual Indicator	2.9	4.3	2.7	3.5	3.5
Numerator	15.3	19.2	15	17.2	17.2
Denominator	5.3	4.5	5.6	4.9	4.9
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	2.9	2.8	2.8	2.7	2.7

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Data issue: Data for 2006 are not available from the Bureau of Health Information and Policy until 2008.
We revised our objectives to reflect the white infant mortality rate of 2004 which was 4.5/1000 and a random fluctuation, therefore, the disparity ratio for 2004 was significantly greater than other years.

Notes - 2005
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/Infant Mortality Module, accessed 04/12/07.

a. Last Year's Accomplishments
The Healthy Birth Outcomes: Eliminating Racial and Ethnic Disparities initiative remains one of the Department of Health and Family Services (DHFS) highest priorities. See

www.dhfs.wisconsin.gov/healthybirths/ for a comprehensive overview of the initiative. Highlights of accomplishments are provided below.

1. Communication and Outreach--Population-Based Services--Pregnant women, mothers, and infants

The Statewide Advisory Committee ws convened in March, August, and November as a primary effort to engage the community in creating meaningful strategies and effective implementation.

A Town Hall meeting was held on June 25, 2007 in Racine with over 100 participants.

A Request for Applications was released for conducting focus groups in Beloit, Kenosha, Madison, Milwaukee, and Racine. ABCs for Healthy Babies is the project conducting concept and message testing among African American women, fathers, and grandmothers. The project has had a very positive response to their recruitment efforts. See www.dhfs.wisconsin.gov/healthybirths/ for a description and recruitment materials. The Communication and Outreach Workgroup provided guidance on the social marketing RFA.

2. Evidence Based Practices--Enabling Services--Pregnant women, mothers, and infants

Smoking cessation services for pregnant women of color in southern and southeastern Wisconsin was provided via First Breath expansion.

Empowering Families of Milwaukee received monitoring and technical assistance.

Collaboration occured with the Milwaukee Family Services Integration on fatherhood initiative and priority services for pregnant women in Wisconsin's Welfare to Work program.

Maternal and Child Health staff participated on the Medicaid Program's Pay for Performance (P4P) Workgroup on Birth Outcomes.

Evidence-based Practices Workgroup selected the following topics for a literature search: Breastfeeding; Prevention of SUID--safe sleep (co-sleeping, back to sleep, smoke, etc.); Community Health Worker/Doula/Home-Visiting; Preconception/interconception care (including unplanned pregnancy and family planning; use of multivitamins with folic acid); UTI detection and treatment; STI detection and treatment (Group B strep; gonorrhea, Chlamydia, etc.); Perinatal mental health/depression screening and treatment; Domestic Violence screening and treatment; and tracking previous poor birth outcomes (LBW/premature baby or infant death).

3. Data Monitoring and Evaluation--Infrastructure Building Services--Pregnant women, mothers, and infants

The Data Workgroup developed selected population and program indicators to track progress in eliminating racial and ethnic disparities in birth outcomes.

An Evaluation Plan was finalized for Empowering Families of Milwaukee Program, in conjunction with the City of Milwaukee Health Department and other academic partners.

Presentations at national, state, and local forums were provided to disseminate data to professionals and community members and seek ideas and information.

Technical assistance and data was provided to Madison/Dane County as they investigate the decline in African American infant mortality.

4. Policy and Funding--Infrastructure Building Services--Pregnant women, mothers, and infants

The MCH Chief Medical Officer and State Health Officer presented data on racial and ethnic disparties in birth outcomes to the Oversight Committee of the Wisconsin Partnership Program. Program Director and DHFS Policy Analyst provided assistance to the author of a White Paper for UW Partnership Program's special funding initiative on birth outcomes.

The State Health Officer was named to Medicaid P4P Steering Committee and meets regularly with the Medicaid Director.

The State Assemblyman and State Senator from Racine secured $250,000 state general purpose revenue funds per year, allocated to the DHFS for the reduction of fetal and infant mortality, and to be awarded to the city of Racine Health Department for program of services, using evidence-based practices, including home visiting.

The Policy and Funding Workgroup plan to develop a set of recommendations after considering the findings from the White Paper for the University of Wisconsin Partnership Program's special funding initiative for eliminating racial and ethnic disparities in birth outcomes.

Efforts to seek funding for community health workers/doulas continued.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Communication and Outreach			X	
2. Evidence Based Practices		X		
3. Data Monitoring and Evaluation				X
4. Policy and Funding				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Communication and Outreach--Population-Based Services--Pregnant women, mothers, and infants

The 2008-2011 Framework for Action has been revised.

The third annual Town Hall meeting was held in June 2008 in Madison.

Guidance is provided to ABCs for Healthy Babies social marketing project.

Three Statewide Advisory Committee meetings will be held.

2. Evidence Based Practices--Enabling Services--Pregnant women, mothers, and infants

First Breath expansion continues.

Collaboration with the Milwaukee Family Services Integration continues.

The Evidence-based Practices Workgroup is researching selected topics.

Participation continues on Medicaid P4P Birth Outcomes Workgroup.

3. Data Monitoring and Evaluation--Infrastructure Building Services--Pregnant women, mothers, and infants

The Data Workgroup will report on measurable indicators to track progress.

Technical assistance for Empowering Families of Milwaukee continues.

4. Policy and Funding--Infrastructure Building Services--Pregnant women, mothers, and infants

The Policy and Funding Workgroup is preparing potential recommendations, such as a Children's Zone, a Community Health Improvement Trust, and Public Health Partnership Plan.

The State Health Officer has regular status updates with the DHFS Secretary.

Efforts of the UW Partnership Program on funding for a special initiative on birth outcomes are supported. The State Health Officer and MCH Chief Medical Officer will attend the invitation-only Wingspread Conference on Infant Mortality.

c. Plan for the Coming Year

1. Communication and Outreach--Population-Based Services--Pregnant women, mothers, and infants

Three Statewide Advisory Committee meetings will be held in 2009.

A Town Hall meeting will be held in June of 2009.

Workgroup recommendations will be presented to full committee.

Findings from focus groups will be disseminated and incorporated into social marketing efforts.

2. Evidence Based Practices--Enabling Services--Pregnant women, mothers, and infants

Ongoing monitoring and technical assistance to the MCH statewide projects will continue.

We will produce and disseminate reports and informational materials on recommended selected topics from Evidence-based Practices Workgroup.

The Empowering Families of Milwaukee Home Visiting Program will transition to the new Department of Children and Families.

Collaboration will occur with the ECCS Program to expand evidence-based and best practices to eliminate racial and ethnic health disparities among vulnerable children ages 0-8.

The City of Racine Health Department will receive technical assistance on their program of reducing fetal and infant deaths.

Collaboration will continue with the Milwaukee Family Services Integration and fatherhood efforts.

We will support the continuation of the Milwaukee FIMR Program and explore expansion to other counties.

Will will participate in efforts to address the lack of Medicaid obstetric services in Kenosha.

3. Data Monitoring and Evaluation--Infrastructure Building Services--Pregnant women, mothers, and infants

The Data Workgroup, with the Statewide Advisory Committee will finalize population and program-based indicators and develop community indicators to track progress on eliminating racial and ethnic disparities in birth outcomes.

A fact sheet on evidence based practices will be produced and disseminated.

We will partner with Madison/Dane County Pubic Health Department and the UW as they investigate the improvement of infant mortality rates among African Americans in Madison and Dane County.

Presentations will be provided at national, state, and local forums to disseminate data to professionals and community members and seek ideas and information.

The City of Racine Health Department wil receive monitoring and technical assistance as they evaluate their program efforts.

4. Policy and Funding--Infrastructure Building Services--Pregnant women, mothers, and infants

Medicaid Pay for Performance efforts for birth outcomes will be tracked.

We will collaborate with the UW Partnership on funding for a special initiative on birth outcomes.

Implementation of Policy and Funding Workgroup recommendations will begin.

We will continue, with partners, to seek other public and private funds to implement Framework for Action strategies.

State Performance Measure 10: *Death rate per 100,000 among youth, ages 15-19, due to motor vehicle crashes.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	21.5	21	20.5	20.5	20
Annual Indicator	28.8	23.5	25.7	24.5	24.5
Numerator	118	96	105	99	99
Denominator	409420	409081	409101	404777	404777
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	20	19.5	19	19	19

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Divsion of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH), http:// dhfs.wisconsin.gov/wish/Mortality Module, accessed 04/29/08.

Notes - 2005

Source: Wisconsin Department of Health and Family Services, Divsion of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH), http:// dhfs.wisconsin.gov/wish/Mortality Module, accessed 05/11/07.

a. Last Year's Accomplishments

1. Educational Activities--Enabling Services--Adolescents

We continued our collaborations with DPI, DOT, Children's Health Alliance of Wisconsin, and Safe Kids to promote the message of motor vehicle safety for teens. Several LHDs selected activities in their communities to address motor vehicle safety in this age group

2. Legislation--Population-Based Services--Adolescents

Support for appropriate legislation and enforcement of existing legislation continued to be a strong method of impacting this performance measure.

3. Local Needs Assessments--Infrastructure Building Services--Adolescents

The Injury Prevention Program provided motor vehicle crash data to agencies and the general public. Injury WISH modules are inclusive of motor vehicle related information for hospitalizations, deaths, and emergency department visits.

4. Injury Coordinating Committee (ICC)--Infrastructure Building Services--Adolescents

The Injury Prevention Coordinating Committee continued to explore ways to address the concerns regarding teen driving, and strategies to address these concerns.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educational Activities		X		
2. Legislation			X	
3. Local Needs Assessments				X
4. Injury Coordinating Committee (ICC)				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Educational Activities--Enabling Services--Adolescents

In order to decrease the incidence of deaths due to motor vehicle crashes, education will continue. Collaborations between DPI, DOT, DHFS (MCH Programs and Substance Abuse) will continue to develop. We will continue to work locally to implement programs that address motor vehicle safety and injury prevention.

2. Legislation--Population-Based Services--Adolescents

We will support appropriate legislation and promote the enforcement of existing legislation. One key way is working with injury prevention partners to disseminate injury briefs on key policies to reduce the motor vehicle injury burden in WI.

3. Local Needs Assessments--Infrastructure Building Services--Adolescents

We work with LHDs and other agencies to obtain data on motor vehicle related statistics in teens in their community. Injury WISH modules are inclusive of motor vehicle related information for hospitalizations, deaths, and emergency department visits. Ongoing education and outreach to promote the availability of this query system and other data resources will be conducted. We are also working with DOT to have better access to CODES data.

4. Injury Coordinating Committee (ICC)--Infrastructure Building Services--Adolescents

As the ICC plans a restructuring, we will look for ways to better incorporate teen driving safety in our goals.

c. Plan for the Coming Year

1. Educational Activities--Enabling Services--Adolescents

Collaboration with organizations such as Safe Kids, DOT, and DPI will continue and additional partners will be identified. The Title V Program will promote intervention strategies to address teen driving at the local level and provide necessary data and information for these activities.

2. Legislation and Policy Changes--Population-Based Services--Adolescents

The potential for additional legislation and policy changes will be evaluated. The Title V Program will partner with other organizations to disseminate information on the benefit and need of this legislation.

3. Local Needs Assessments--Infrastructure Building Services--Adolescents

Staff will continue to work with local agencies to provide county-specific data and technical support. The Injury Prevention Program and DOT will continue making motor vehicle crash data more accessible to agencies and the general public. We will continue work with CODES data started in 2008.

4. Injury Coordinating Committee (ICC)--Infrastructure Building Services--Adolescents

The Injury Coordinating Committee his group will be used to steer activities around teen driving and motor vehicle safety around the state.

E. Health Status Indicators

2005 data are required by the TVIS for the Health Status Indicators (HSIs), forms 20 and 21 for the 2007 Title V Block Grant Application; however, for the majority of these indicators (with the exception of program data for chlamydia [#05A and #05B], 2005 data are not available. Therefore, we used the most recent available data (in most cases 2004 data) as estimates for 2005 and so indicated in a data note. Data for #01A - #03C are maintained by the DHFS, DPH, Bureau of Health Information and Policy, Vital Records Section; 2005 data will not be available until 2007. Since September 2003, collection of hospitalization data for the unintentional and non-fatal injury indicators (#04A - #04C) is the responsibility of the Wisconsin Hospital Association, and access by DHFS to recent discharge data depends on a data use agreement.

FORM 20:
Health Status Indicators #01A - #6B.

#01A: The percent of live births weighing less than 2500 grams --
The percent of live births weighing less than 2500 grams has increased gradually since 2000 from 6.5% to 7.0% in 2004; Wisconsin's percent of low birth infants in 2004 is lower than the U.S. preliminary rate of 8.1% in 2004. Twins or other multiple births made up 26.1% of all low birthweight births in 2004.

/2008/ Compared with the overall incidence of low birthweight in 2005 (7.0%), higher percentages of low birthweight infants were born to: a) Mothers who received no prenatal care (22.6%), b) Mothers less than 15 years old (14.0%), c) Non-Hispanic black women (13.7%), d) Women who smoked during pregnancy (11.4%), e) Women who were unmarried (9.3%), and f) women with less than a high school education (9.3%). In 2005, 10.6% of infants born to mothers less than 18 years of age weighed less than 2,500 grams at birth compared with 6.9% among mothers age 18 and older. Among premature infants, 42% were of low birthweight. Twins or other multiple births made up 25.9% of all low birthweight births in 2005. Low birthweight is a key long term outcome for evaluation of the Medicaid prenatal Care coordination benefit and the Empowering Families in Milwaukee home visiting program.

Low birthweight and prematurity have been identified as major contributors (along with unsafe infant sleep) to the disparities in birth outcomes among Wisconsin's racial and ethnic minority populations. A number of the action steps within the Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes include educational efforts and interventions to prevent these conditions, such as smoking cessation for pregnant women, screening and treatment of infections during pregnancy, and educating women about the signs and symptoms of preterm labor. The Medicaid Program produced a fact sheet on Medicaid costs associated with low birthweight births. See Supporting Data at www.dhs.wisconsin.gov/healthybirths/. Future program efforts will include raising public awareness, promoting best practices among providers and consumers, and seeking funding for culturally-appropriate and effective messages and interventions. We will continue to join others, such as the March of Dimes and the Association of Women's Health, Obstetric and Neonatal Nurses, in their conferences and summits on prematurity. //2008//

/2009/ Compared with the overall incidence of low birthweight in 2006 (6.9%), higher percentages of low birthweight infants were born to: a) Mothers who received no prenatal care (21.3%), b) Mothers less than 15 years old (7.6%), c) Non-Hispanic black women (13.5%), d) Women who smoked during pregnancy (10.8%), e) Women who were unmarried (9.2%), and f) Women with less than a high school education (8.8%). In 2006, 11% of infants born to mothers less than 18 years of age weighed less than 2,500 grams at birth compared with 6.8% among mothers age 18 and older. 42% of premature infants were of low birthweight. Twins or other multiple births made up 24.8% of all low birthweight births in 2006. Low birthweight remains a key long term outcome for evaluation of the Medicaid Prenatal Care Coordination benefit and the Empowering Families in Milwaukee home visiting program.

Title V staff are participating on a Medicaid Pay-for-Performance Workgroup to provide recommendations for improving birth outcomes among Medicaid women. DPH awarded Minority Health Program funding for consumer and community focus group development and testing of culturally appropriate messages for public information campaigns on the leading causes of poor birth outcomes for African American women. The Data Workgroup of the Statewide Advisory Committee on Eliminating Racial and Ethnic Disparities is choosing low birthweight as one indicator to track. The Evidenced-based Practices Workgroup has chosen to review the literature for a number of related topics (see SPM #9). //2009//

#01B: The percent of live singleton births weighing less than 2500 grams --
The percent of live singleton births weighing less than 2500 grams has remained about the same

since 2002 when it was 5.2%; in 2004, it was 5.3%. In 2004, higher percentages of low birthweight infants were born to: mothers who receive no prenatal care (23.1%), non-Hispanic black women (13.7%), women who smoked during pregnancy (11.2%), teens less than 15 years old (14.3%), women who were unmarried (9.6%), and women with less than a high school education (9.0%).

/2008/ See #01A. //2008//

/2009/ See #01A. //2009//

#02A: The percent of live births weighing less than 1500 grams --
In 2004, the percent of live births weighing less than 1500 grams was 1.2% compared to 1.3% in 2003.

/2008/ In 2005, the percentage of very low birthweight infants in Wisconsin weighing less than 1500 grams was 1.3% among all births, and 1.0% of births to whites, 1.3% of births to Hispanics, 3.5% of births to blacks, 1.3% of births to American Indians, and 1.2% of births to Laotian/Hmong.

The Title V program has used the Perinatal Periods of Risk (PPOR) model to analyze fetal and infant mortality data (see PPOR Charts and Graphs on the follow page). The PPOR model identifies four categories based on birthweight and time of death: Maternal Health/Prematurity (fetal, neonatal and infant deaths, 500-1499 grams), Maternal Care (fetal deaths, 1500+ grams), Newborn Care (neonatal deaths, 1500+ grams), Infant Health (postneonatal deaths , 1500+ grams). Data in these categories is compared to a reference population with good outcomes (non-Hispanic white women in Wisconsin, >20 years old with 13+ years of education). The difference identifies the number of excess deaths and percent contribution of excess deaths. The PPOR analysis based on 2002-2004 Wisconsin data identified fetal and infant deaths with birthweights less than 1500 grams accounted for 34% of the excess deaths for the population as a whole, 50% of excess deaths for blacks, 39% of excess deaths for Hispanics, 26% of excess deaths for whites, 51% of excess deaths in the city of Milwaukee, and 50% of excess deaths for blacks in the city of Milwaukee. Very low birthweight is a significant factor in the disparities in infant mortality rates for blacks in Wisconsin. //2008//

/2009/ In 2006, the percentage of very low birthweight infants in Wisconsin weighing less than 1,500 grams was 1.3% among all births, and 1.0% of births to Whites, 1.3% of births to Hispanics, 3.0% of births to Blacks, 1.7% of births to American Indians, and 1.1% of births to Laotian/Hmong. The disparity between Black infants and White infants is greater for very low birthweight than for low birthweight. In 2004-2006, African American infants were more than three times as likely to be born at very low birthweight as were white infants.

Public Health of Madison and Dane County is reporting a dramatic decline over the past five years in African American infant mortality, coinciding with a marked decline in extreme prematurity. //2009//

#02B: The percent of live singleton births weighing less than 1500 grams --
The percent of live singleton births weighing less than 1500 grams was .9% in 2004, a slight decrease from 1.0% which was the rate from 2000-2003.

/2008/ See #02A. //2008//

/2009/ See #02A. //2009//

#03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger --
The rate of unintentional injuries among children aged 14 years and younger fluctuated during the past 5 years. The rate of deaths in 2004 was 7.3, compared to 8.1 in 2003. From 2001 to 2004,

the largest number of deaths was from occupants involved in motor vehicle crashes, followed by death from suffocation.

/2008/ The rate of unintentional injury death among children ages 14 years and younger fluctuated during the past 5 years. The rate of death in 2005 was 9.7, compared to 7.2 in 2004. This rate increase is a result of 26 additional injury-related deaths in 2005 as compared to 2004. While the rate increase is not statistically significant, the death of 26 more children is cause for concern. The leading cause of unintentional injury deaths continues to be due to motor vehicle crashes, but much of the increase of unintentional injury fatalities in 2005 was an increase in deaths due to suffocation. //2008//

/2009/ In 2006, the rate of unintentional injury deaths among children 14 years of age and younger was 7.2 per 100,000. This is a decrease from 2005, when the rate of death was 9.7 per 100,000. This rate decrease represents 23 fewer unintentional injury deaths in the target population. Motor vehicle-related deaths were not the most common cause of deaths as has been the trend. Rather, the most common cause of these deaths was suffocation, followed by motor vehicle-related deaths. //2009//

#03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes --
Aside from a slight increase in 2002 to 3.8, the rate of unintentional deaths from motor vehicle crashes among children aged 14 years and younger has steadily decreased from 3.3 in 2001 to 2.9 in 2004.

/2008/ The rate of unintentional deaths from motor vehicle crashes among children ages 14 years and younger has remained relatively consistent over the past five years. There was a slight increase from 2.5 per 100,000 population in 2004 to 2.8 per 100,000 population in 2005, due to an additional three deaths in 2005. //2008//

/2009/ The rate of unintentional deaths from motor vehicle crashes among children ages 14 years and younger was 1.8 per 100,000. This is a decrease from 2.8 per 100,000 in 2005. //2009//

#03C: The death rate per 100,000 for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes --
Motor vehicle accidents continue to be the leading cause of death for youth 15 through 24 years old. In 2004, the rate of death due to motor vehicle accidents was 26.0, a slight decrease from 30.0 in 2003. Overall, the rate has fluctuated since 2001 and there is no discernable trend.

/2008/ In 2005, the rate of death due to motor vehicle crashes in youths ages 15 to 24 years was 26.3 per 100,000 population, a slight increase from 2004. However, there is no significant trend or change in rate over the past five years. //2008//

/2009/ In 2006, the rate of death due to motor vehicle crashes in youths ages 15 to 24 years was 25.7 per 100,000 population. This rate represents 7 fewer deaths than in 2005. However, there is no significant trend or change in rate over the past five years. //2009//

#04A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger --
Since 2002, the rate of all nonfatal injuries among children aged 14 years and younger decreased from 352.1 to 293.2 (there were programming errors in the data run for 2001). Overall, falls, poisoning, and motor vehicle-related injuries account for about 50% of nonfatal injuries for this age group.

/2008/ In 2005, the rate of all nonfatal injuries among children ages 14 years and younger was 282.4 per 100,000 population. The leading causes of these deaths were: unintentional falls, poisoning (both unintentional and self-inflicted), and motor vehicle crashes. //2008//

/2009/ In 2006, the rate of all nonfatal injuries among children ages 14 years and younger was 256.1 per 100,000 population a decrease from 2005. The leading causes of these injuries were: unintentional falls and poisoning (both unintentional and self-inflicted). //2009//

#04B: The rate per 100,000 of all nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger --
From 2001-2004, motor vehicle-related crashes accounted for about 10% of nonfatal injuries among children aged 14 years and younger. In 2004, the rate was 29.2, a slight increase from the 2003 rate of 27.3. Overall, the rate has fluctuated since 2001 and there is no discernable trend.

/2008/ The rate per 100,000 population of nonfatal injuries due to motor vehicle crashes among children ages 14 years and younger was 26.0. This does not represent a significant change from the rate in the past five years. //2008//

/2009/ In 2006, the rate per 100,000 population of nonfatal injuries due to motor vehicle crashes among children ages 14 years and younger was 23.2, a slight decrease from 2005. //2009//

#04C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15-24 years --
From 2001-2004, motor vehicle-related crashes accounted for 23% of all nonfatal injuries among youth aged 15-24, and 79% of those injuries were occupant motor vehicle traffic crashes. For the period 2001-2004, the 2004 rate was the lowest at 147.0, compared to the highest rate of 207.6 in 2002; there is no discernable trend.

/2008/ The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth ages 15-24 years was 144.7 in 2005. This is a slight decrease from 2004, and a statistically significant decrease from the rate in 2003. //2008//

/2009/ In 2006, the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth ages 15-24 years was 149.3. This is a slight increase from 2005. //2009//

#05A and 05B: The rate per 1000 women (aged 15 through 19 years and 20 through 44 years) with a reported case of Chlamydia --
Though reported chlamydia morbidity has remained relatively stable among Wisconsin women since 2001, the total annual reported morbidity has increased, with greater numbers of men reported in subsequent years. Increasing focus in the STD Program to reach partners may have contributed to this increase in males reported with chlamydia. Reported morbidity rates of chlamydia among women over the past 5 years appear to be stable during a time when the volume of screening has steadily increased and significantly more sensitive tests used. This stabilization may be attributable to the impact of the STD Program on reducing morbidity among women through statewide selective screening programs for women at high risk in Wisconsin. The rate in 2001 for younger women is almost three times that of older women; in 2004, the rate for women 15-19 was 27.8 compared to a rate of 8.5 for women 20-44.

/2008/ The rates per 1,000 women for 15-19 year olds and 20-44 year olds with a reported case o f Chlamydia have steadily increased each year from 2001-2005. A steady increase in the volume of tests performed in women for chlamydia at the Wisconsin State Laboratory of Hygiene (WSLH), has also been observed, with 42,085 tests performed in 2001 vs. 50,615 tests performed in 2005. Though not all reported cases had tests performed at the SLH, tests done through the SLH contributed ~ 28% of reported positives among 15-19 year old women and ~ 16% of reported positives among 20-44 year old women. //2008//

/2009/ Reported rates of chlamydia in 15-19 year old and 20-44 year old women continued to increase in 2006 (5,539 and 8,609 per 100,000 respectively) and 2007 (5,621 and 8,703 per 100,000 respectively). In addition, alarming disparities persist by region and race. The 2007 rates of reported chlamydia among African American 15-19 year old girls (12,671 per 100,000) was 13 times the rate reported among white girls (955 per 100,000) living in Wisconsin. In Milwaukee County, 1 of 86 (1,169 per 100,000) white girls age 15-19 were reported with chlamydia in 2007, compared to 1of 105 (955 per 100,000) reported with chlamydia state wide.

In 2006, there were 30,398 reported STD in Wisconsin among all ages, including Chlamydia, gonorrhea, syphilis, and HSV. Chlamydia accounts for 66% of all reported STDs, and 72.1% among ages 15-19. Ages 15-19 accounted for 32% of all reported cases, or a rate of 2,353 per 100,000. The Chlamydia-specific rate per 100,000 ages 15-19 was 1,697 in 2006. After a steady increase from 1997 to 2003, reported cases of Chlamydia have remained steady from 2004 through 2006. Ages 20-44 account for 68% of reported STDs, and ages 20-29 account for 58% of reported STDs. The rate per 100,000 in 2006 (for the above STDs) was 2,551 for ages 20-24, 1,376 for ages 25-29, and 597 for ages 30-34. Selective screening criteria will be re-evaluated in 2008 to improve the effectiveness in identifying persons at increased risk of infection.

Source:
http://dhs.wisconsin.gov/communicable/STD/2006Data/2006STDdata/Presentations/Youth15-19.ppt#510,1, Sexually Transmitted Disease among persons 15-19 years of age in Wisconsin. Wisconsin STD Surveillance Data Cases diagnosed in 2006. //2009//

FORM 21:
Health Status Indicators #06A - #12. These data are demographic and describe Wisconsin's population by number of births and deaths by age group and by race/ethnicity, miscellaneous demographic indicators for Wisconsin's children, and Wisconsin's population by poverty level and urban/rural proportions. For the majority of these indicators, 2005 data are not available; therefore, we have marked the data "provisional" on the respective form and used 2004 data in lieu of 2005 data.

Wisconsin's birth and death data (#07A - #08B) are maintained in retrospective administrative data bases by the DHFS, DPH, BHIP, Vital Records Section; 2005 data will not be available until 2007. Data for #09B come from several state agencies and there is not a consistent methodology across agencies for reporting of race/ethnicity; additionally, program changes and staff turnover are a limitation for reporting these data consistently from year to year; we have used 2005 data if available, and noted if 2005 data were not available. Data for #10 - #12 are estimates from the U.S. Census Current Population Survey or the American Fact Finder.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

#06A and #06B: Demographics: Infants and children 0-24 by race and ethnicity --
Of the 1,882,887 Wisconsin residents under 25 years of age, 85.6% are white, 8.4% are African American, 6.3% are Hispanic/Latino, 1.2% is American Indian, 2.7% are Asian, and 1.9% are multiracial. The fastest growing ethnic group in Wisconsin is Hispanic/Latino. Although 6.3% of the total population under 25 is Hispanic/Latino, 8.4% of babies less than one year of age are in this group.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

#07A and #07B: Demographics: Live births by maternal age and race and ethnicity --
In Wisconsin, 70,131 infants were born to women in 2004. Of that total, 8.7% were born to women under 20 years of age, 77.5% were born to women 20 to 34 years of age, and 13.8% were born to women 35 and older. Teen pregnancy continues to be a problem in the African American community. 23.3% of African American babies were born to mothers under 20 while only 6.8% of white babies were born to mothers in this age group. 14.7% of white babies were born to mothers 35 and older while only 6.5% of African American babies were born to mothers in this age group. 5,915 babies were born to Hispanic/Latino women in Wisconsin in 2004. 15.5% of Hispanic/Latino babies were born to mothers under 20 years of age, 76.6% were born to mothers 20 to 34 years of age, and 7.9% were born to mothers 35 and older. From 1994-2005, the past decade, the proportion of Wisconsin births to non-Hispanic white women decreased from 83% to 77%, reflecting our increasing population diversity, primarily due to Hispanic/Latino immigration.

/2008/ No significant change. //2008//

/2009/ There were 72,302 births that occurred to Wisconsin residents in 2006. (Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Births and Infant Deaths, 2006 (PPH 5364-06). September 2007). Overall, 75.4% of births where to white mothers, followed by 9.7% to African American mothers, 1.6% to American Indian mothers, 9.4% to Hispanic/Latino mothers, 1.7% to Laotian/Hmong mothers, and 2.0% to Other Asian mothers. 8.4% were born to women under 20 years of age, 77.8% were born to women 20 to 34 years of age, and 13.7% were born to women 35 and older. Teen births (to women <20 years of age) represented 8.4% of births overall. However, by race/ethnicity, African American teens have the highest percentage of births at 29.9%, followed by Laotian/Hmong at 16.5%, American Indian at 15.8%, Hispanic/Latino at 14.2%, and White at 5.6%. Wisconsin's race/ethnicity-specific birth rates have decreased since 1990 for non-Hispanic whites, African American, and Asians; the American Indian birth rate has gradually increased since 1990 from 85.7 per 1,000 to 95.2 in 2006, and the Hispanic/Latino birth rate increased from 85.1 in 1990 to 111.8 in 2006. //2009//

#08A and #08B: Demographics: Deaths of infants and children ages 0-24 by age group and race/ethnicity --
1,158 Wisconsin children died in 2004. 36.2% were under one year of age, 5.7% were 1 to 4, 4.0% were 5 to 9, 5.7% were 10 to 14, 19.8% were 15 to 19, and 28.4% were 20 to 24. Infant mortality is much higher for African Americans than for whites. Of the 219 deaths among African Americans under 25 in 2004, 58.4% (128) were babies under one year of age, a rate of 19.42 per thousand. By comparison, of the 877 deaths among whites under 25 in 2004, 31.0% (272) were babies under one year of age, a rate of 4.53 per thousand. 67 Hispanic children died in Wisconsin in 2004. More than 50% (35) were babies under one year of age, a rate of 5.92 per thousand.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

#09A and #09B: Miscellaneous demographic data for children, 0-19 --
There are limitations to these indicators: they are not consistently reported by age and race/ethnicity across state agencies, they are not defined consistently (numbers, rates, percentages), and methodologies for their collection and reporting change from year to year and by agency. About 27% of Wisconsin's population is children, ages 0-19. Overall, Wisconsin's children do well: they have a relatively low high school drop out rate, low rate of juvenile crime arrest, and enrollment numbers for Medicaid/BadgerCare have been increasing. However, when examined by race/ethnicity, there are outstanding disparities; for example, there are almost as many black children in foster care home as white children, even though black children comprise

9% of the children 0-19, while white children account for 85%. Other examples are the rates of juvenile violent crime arrest and percentage of high-school drop outs: children of color have higher rates than whites. Section III - State Overview, of the 2007 MCH Title V Block Grant Application, describes other significant disparities for Wisconsin's children.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

#10: Geographic living area for all resident children 0-19 --
In 2004, 1,482,334 children under the age of 20 lived in Wisconsin. 15.4% lived in rural areas and 84.6% lived in urban areas.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

#11: Poverty levels --
Approximately 5.5 million people lived in Wisconsin in 2004. Four percent (about 220,000) subsisted at less than 50% of the federal poverty level, 9% (about half a million) at 100% FPL, and 24% (about 1.3 million) at 200% FPL.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

#12: Poverty levels for children 0-19 --
Approximately 1.5 million children under 20 lived in Wisconsin in 2004. Five percent (about 75,000) subsisted at less than 50% of the federal poverty level, 12% (about 180,000) at 100% FPL, and 28% (about 420,000) at 200% FPL.

/2008/ No significant change. //2008//

/2009/ No significant change. //2009//

F. Other Program Activities

Public Health Information and Referral (PHIR) Services for Women, Children and Families (hotline services) - Gundersen Lutheran Medical Center - LaCrosse -- Since 1995, the MCH Hotline has provided comprehensive information on the various MCH programs in Wisconsin. During this time, the need has grown for other state health-focused programs to establish a toll-free hotline and supporting information and referral service. In order to avoid unnecessary duplication, the state combined the needs of these programs into one comprehensive PHIR service for women, children and families provided by one agency, Gundersen Lutheran Medical Center, La Crosse, Wisconsin. The purpose of developing a comprehensive hotline system is to streamline the mechanism by which individuals and families can receive information and access specific providers in Wisconsin. This agency combines information and referral services for the following programs:

- MCH Hotline, including the CYSHCN Program and reproductive health (800) 722-2295
- Services Hotline for Women, Children and Families (ACT 309) (877) 855-7296
- Supplemental Nutrition Program for Women, Infants and Children (WIC) (800) 722-2295
- Wisconsin Medicaid, including HealthCheck and Healthy Start (800) 722-2295
- Wisconsin Birth to 3 Program & Regional CYSHCN Centers (First Step Hotline) (800) 642-7837

In 2004 the MCH Hotline received 8,549 calls; an increase of 516 calls from 2003. The website

address is www.mch-hotlines.org.

In 2004, the First Step Hotline received 2,103 calls in 2004; an increase of 604 calls from 2003. In addition, the CYSHCN Program maintains a toll-free phone number (800) 441-4576 to assist parents and providers regarding children with special health care needs.

The Statewide Poison Control System was implemented on July 1, 1994, with state GPR funds ($375,000) and a 50% match requirement from each regional poison control center. The program provides Wisconsin citizens with the following services: a toll-free hotline allowing easy access for poison control information; quality interpretation of poison information and needed intervention; and education materials for consumers and professionals. As of July 1, 2001 the Wisconsin Poison System contract solely supports the poison control center located at the Children's Hospital of Wisconsin (CHW), Milwaukee. The University of Wisconsin Hospital and Clinics, Madison continues to support the poison control system in Wisconsin by staffing a Poison Prevention Education Center. The Children's Hospital of Wisconsin Poison Center received 64,836 total calls during CY 2004; 43,718 were human exposure calls. In February 2005 this center received full certification by the American Association of Poison Control Centers (AAPCC). This new certification makes the Poison Center the first in Wisconsin history to become nationally certified.

/2007/ The MCH Hotline received 9,025 calls in 2005; an increase of 476 calls from 2004. The Wisconsin First Step Hotline received 2,185 calls in 2005; an increase of 82 calls from 2004. The Children's Hospital of Wisconsin Poison Center received 76,997 total calls in CY 2005; nearly 60% of the calls were regarding a poison exposure. //2007//

/2008/ The MCH Hotline received 11,196 calls in 2006; an increase of 2,171 calls from 2005. The Wisconsin First Step Hotline received 2,344 calls in 2006; an increase of 159 calls from 2005. The Wisconsin Poison Center received 60,764 total calls in CY 2006; nearly 70% of the calls were regarding a poison exposure. //2008//

/2009/ The MCH Hotline received 8,634 calls in 2007; a decrease of 2,562 calls from 2006. The Wisconsin First Step Hotline received 1,932 calls in 2007; a decrease of 412 calls from 2006. The Wisconsin Poison Center received 52,834 total calls in CY 2007; nearly 85% of the calls were regarding a poison exposure.

This decrease is due to the Hotline not needing to take calls for the BadgerCare program in 2007. (In 2006, there were 1,669 calls related to BadgerCare.) Also, calls made to an agency on behalf of a caller are currently logged as 1 call whereas previously they were recorded as 2 calls, from the caller and to the agency.

The Wisconsin Birth Defects Prevention and Surveillance Program released a new report, "Wisconsin Birth Defects Registry 2007 Annual Report", (PPH 40150). The report can be downloaded, viewed, and printed from the website at http://dhfs.wisconsin.gov/DPH_BFCH/cshcn/bdpsdesc/bdpssystem.htm. The program focuses on prevention and access to services through 3 projects. The 'Women's Health Now and Beyond Pregnancy" project is a preconception program promoting the use of multi-vitamins with 400 mcg of folic acid and providing the multi-vitamin to women after delivery. Another project is the "Wisconsin Stillbirth Services Program" at the University of Wisconsin's Clinical Genetics Center to help investigate the causes of stillbirths (http://www.wisc.edu/wissp/).

The third project funded by the Wisconsin Birth Defects Prevention and Surveillance Program is the "Nourishing Special Needs Infants and Children: Wisconsin WIC Partnership." This pilot project, currently at 8 WIC sites though-out Wisconsin, is a collaborative effort between WIC Nutritionists, DPH Regional Office, State WIC and CYSHCN programs, and the UW-Pediatric Pulmonary Center. The project builds on the

existing capacity of the WIC program to improve access to nutrition services and support for infants and children with birth defects and other special health care needs. Program goals are to: identify nutrition-related concerns early, provide access to formula and medical nutrition products, make referral to other programs, provides care giver education and support, screen for the need for medical nutritional therapy, and assist families by communicating with providers. //2009//

G. Technical Assistance

Wisconsin requests technical assistance for our adolescent health program. We are requesting assistance from AMCHP to facilitate collaboration with other state and territorial adolescent health coordinators in order to improve access to national resources and experts on adolescent health.

Wisconsin requests technical assistance on MCHB's expectation of how the work and activities of the ECCS Program need to be integrated into the ongoing MCH/CSHCN Programs, with particular attention needed in the areas of Mental Health and Social-Emotional Development, Parenting Education, and Family Support.

Wisconsin requests technical assistance in designing and writing specifications for an on-line child health profile to be integrated into the existing WI Pubic Health Integrated Network (PHIN) and the Secure Public Health Electronic Record Environment (SPHERE). The child health profile would be used by primary care providers and the public health community.

Wisconsin requests technical assistance and information related to eliminating racial and ethnic disparities in birth outcomes. This could include on site-visits, expert consultation, and information from other states and cities (similar in demographics to Milwaukee, WI) who have implemented best practices and effective methods.

/2007/ No significant changes. //2007//

/2008/ Wisconsin requests technical assistance to check in with other states to see what they are doing with their MCH Advisory Committees.

Wisconsin requests technical assistance to see how other states are capturing their MCH services supported by their MCH dollars, vs. capturing all their MCH related services that are not covered by their MCH dollars but are likely to be offered because of the MCH support/infrastructure/programming.

Wisconsin requests technical assistance in identifying and reviewing core competencies of its MCH staff. How can we assure that we are addressing the MCH program needs at the local, state, and federal levels with declining and/or changing staffing patterns.

Wisconsin requests technical assistance in exploring what other states have done as far as the design, development and promotion of a child health profile that could be used by primary care providers and the public health community. //2008//

/2009/ Wisconsin requests technical assistance in preparing and planning for our next five year needs assessment. We are looking for guidance and ideas for conducting our needs assessment, integrating our 2020 State Health Plan planning efforts and our priorities from our present needs assessment and the future needs assessment efforts.

Wisconsin requests technical assistance in identifying what other state MCH programs are using as their data collection tool/system for reporting their grant required data and performance measures. Is there off the shelf software states are using or have states developed their own systems? Can they share their systems with other states? //2009//

V. Budget Narrative

A. Expenditures

Significant Variances - Forms 3, 4, and 5 -- 2006 Budgeted/Expended

Form 3

State Funds
This variance, a decrease of $1,150,058 (10.9%), is due to a decrease in Match reported by local health agencies ($888,495) and a reduction in state Maintenance of Effort funds ($261,563).

Program Income
This variance, an increase of $2,021,138 (58%), is due entirely to an increase in the amount of Program Income reported by local agencies providing family planning/reproductive health services.

Form 4

Pregnant
This variance, an increase of $286,182 (19.7%), is due to an increase in the amount of Program Income reported by local agencies providing family planning/reproductive health services ($143,247), an increase in services provided by local health agencies ($163,795) and an increase in related state operations expenditures ($74,144). There were decreases in the Match provided by local health agencies ($65,376) and state Maintenance of Effort funds ($29,628).

Infant
This variance, a decrease of $266,468 (10.5%), is due primarily to a decrease in related state operations ($203,702) and a decrease in services reported by local health agencies ($90,308). There were modest increases in Match provided by local health agencies ($14,643) and state Maintenance of Effort funds ($13,910). There was a slight decease in Program Income provided by local health agencies providing family planning/reproductive health services ($1,011)

Other
This variance, an increase of $631,460 (13.1%), is due primarily to increases in Program Income from local agencies providing family planning/reproductive health services ($1,011,285) and an increase in related state operations ($207,197). These increases were offset by decreases in services reported by local health agencies ($125,519) and Match reported by local health agencies ($446,275). There was a modest decrease in state Maintenance of Effort funds ($15,228).

Form 5

Direct
This variance, an increase of $1,394,251 (11.5%), is due primarily to an increase in Program Income reported by local agencies providing family planning/reproductive health services ($1,819,024). This increase was offset by decreases in Match provided by local health agencies ($188,915) and state Maintenance of Effort funds ($247,767). There was a modest increase in related state operations funds ($11,910)

Enabling
This variance, a decrease of $430,045 (10.1%), is due to a decrease in Match provided by local health agencies ($364,420) and a decrease in services provided by local health agencies ($65,625).

Population-Based

This variance, a decrease of $130,236 (11.1%), is due to a decrease in the amount of Match provided by local health agencies ($109,868) and a decrease in services provided by local health agencies ($20,368).

B. Budget

The Title V MCH/CYSHCN Program award of $10,800,119 is budgeted into two broad categories, State Operations and Local Aids. Please see the attached file for full details.

See Attachment to Section V. B. - Budget (Title V MCH/CYSHCN Program Budget)
An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.